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Publications



ONTARIO

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Wednesday, January 22, 1964.

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INCORPORATED

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Dr. J.W. Macmillan.

SUBMISSION OF THE SAULT STE. MARIE AND DISTRICT
GROUP HEALTH ASSOCIATION

Appearances: John H. O'Leary, O.C.,
John G. Barker,
T.A. Ferriter, M.D.,
Gordon Milling, J.R.D.

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SUBMISSION OF THE CANADIAN ARTHRITIS AND RHEUMATISM
SOCIETY, ONTARIO DIVISION

Appearances: Dr. M.J. Swanson
Dr. H.A. Smythe
Dr. J.D. Pearson

MR. W.S. MAJOR

MISS HELEN McARTHUR

MR. P.J. McLOONEY

MR. CARMAN A. NAYLOR

MR. HARRY SIMON



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---On commencing at 10:00 a.m. PROVINCE OF ONTARIO

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MEMBERS OF ENQUIRY:

DR. J. GERALD HAGEY -- Chairman

MRS. J.A. AYLEN

DR. WILLIAM BUTT

MISS HELEN CARPENTER

MISS ALMA REID

DR. DALTON J. CASWELL

MR. A. ROY COULTER

DR. R.J. GALLOWAY

DR. JOHN HAMILTON

MR. W.S. MAJOR

MISS HELEN McARTHUR

MR. P.J. MULROONEY

MR. CARMAN A. NAYLOR

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2 Secondly, because of the frequency of illness

3 SUBMISSION OF THE ONTARIO PSYCHOLOGICAL ASSOCIATION

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8 THE CHAIRMAN: Ladies and gentlemen, am I right
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9 in assuming that you are the delegation of the Ontario
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14 DR. HODDINOTT: Mr. Chairman, I am Dr.

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Hoddinott, Executive Secretary of the Ontario Psychological

15 psychological services rendered by registered psychologists be
Association. This is Dr. MacMillan, President-elect.

16 included among the benefits of the insurance plan.

17 THE CHAIRMAN: Thank you. If you wish to sit

Dr. MacMillan and myself would be glad to

down make yourself comfortable and proceed, please feel free

18 answer any questions that the Committee may have on matters
to do so.

19 contained in my brief.

20 DR. HODDINOTT: Mr. Chairman, Ladies and

21 THE CHAIRMAN: Thank you, Miss Carpenter?

Gentlemen, in submitting the brief on behalf of the Ontario

22 MISS CARPENTER: I was interested in the brief,

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23 in your suggestion that the psychologist be included and that

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24 his services be given on a fee for service basis. You do bring
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Gentlemen, in submitting the paper on behalf of the Ontario
Psychological Association, we would like to emphasize the
following points: First of all, no scientific distinction
can be drawn between so-called mental illness and organic
diseases and it is now commonly accepted that psychological



1 and physical elements are present in all illnesses.

2 You see this. Secondly, because of the frequency of illness

3 requiring psychological and psychiatric consultation and

4 treatment, an insurance plan that pretends to be comprehensive

5 must cover this type of disorder.

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7 scientific information available, is to transfer responsibility

8 for psychiatric and psychological service to community hospitals

9 and clinics. Such a program will be destroyed if service for

10 the mentally ill is not included in the present insurance

11 scheme. For these and other reasons the Ontario Psychological

12 Association would recommend that the proposed program of health

13 insurance include parallel assistance for both the physically

14 ill and the mentally and emotionally disturbed, and that

15 psychological services rendered by registered psychologists be

16 included among the benefits of the insurance plan.

17 THE CHAIRMAN: Thank you. If you wish to sit

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21 DR. HODDINOTT: Mr. Chairman, Ladies and

22 THE CHAIRMAN: Thank you. Miss Carpenter?

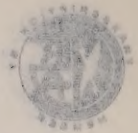
23 MISS CARPENTER: I was interested in the brief,

24 in your suggestion that the psychologist be included and that

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20 THE CHAIRMAN: Thank you, Miss Carpenter?

21 MISS CARPENTER: I was interested in the brief,

22 in your suggestion that the psychologist be included and that

23 his services be given on a fee for service basis. You do bring

24 out in your brief that by far the largest majority of the

25 psychologists are in a position to which they are salaried, and



1 that about 20 psychologists now are engaged in private practice.
2 You see this extending further. This is a comment on page 4.
3 Do you want to comment on that?

4 DR. HODDINOTT: In a sense, the figure 20 is
5 somewhat misleading. This represents 20 psychologists who are
6 in full time private practice but in fact private referrals are
7 accepted by a substantial number of psychologists, usually
8 referrals from a physician or a psychiatrist.

9 MISS CARPENTER: But this is in addition to
10 what his usual institutional employment is. So this is over
11 and above his salaried position?

12 DR. HODDINOTT: Yes.

13 MISS CARPENTER: What is the range of salary
14 that a psychologist earns now in his salaried service?

15 DR. HODDINOTT: This is a complicated question.
16 I could give you the salary range for a Ph.D. psychologist which
17 is the group of psychologists that eventually will form the
18 group called registered psychologists under the Registration
19 Act. This ranges in the Ontario Government Service, a starting
20 salary of \$6900.00 a year to a maximum salary of \$8600.00 a year.

21 MISS CARPENTER: This is the Ontario Mental
22 Health Hospitals?

23 DR. HODDINOTT: Yes. This of course is nowhere
24 near the range of a psychologist salary employed by other groups.

25 MISS CARPENTER: What would that range be?



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near the range of a psychologist salary employed by other groups

MISS CARPENTER: What would that range be?



1 DR. HODDINOTT: The minimum range in Boards of
2 Education for the minimum of a comparable individual would be
3 \$8500.00 a year to approximately \$12,000.00 a year.

4 MISS CARPENTER: On page 14 you say: "A fee
5 schedule for psychological services has been proposed to
6 the membership of this Association which provides for a minimum
7 consultation fee of \$25.00." I wonder if a patient coming
8 back -- does a patient come back for more than one consultation
9 and if so is the fee for every consultation, for continuing
10 service, \$25.00?

11 DR. HODDINOTT: No. It was the initial
12 consultation fee. It was \$25.00 but the minimum hourly patient
13 fee and the continuing consultation fee was recommended at
14 \$15.00 an hour.

15 MISS CARPENTER: \$15.00 an hour?

16 DR. HODDINOTT: That is right. It should be
17 clarified that this is not \$15.00 per contact hour. That is
18 the hour spent with the patient. I got it the wrong way round.
19 \$15.00 per hour is based only on the time the practitioner
20 would spend with the patient and of course in psychological
21 work there is approximately equal time required to score, in-
22 terpret the material you may use when a patient is absent.

23 MISS CARPENTER: How long is the average
24 consultation? Is it an hour?

25 DR. HODDINOTT: It would depend very much on

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MISS CARPENTER: How long is the average

consultation? Is it an hour?

DR. HODDINOTT: It would depend very much on



1 the type of problem referred. The initial consultation, in my
2 own experience, would require me to see the patient for at
3 least an hour and a half to two hours. This would vary, to some
4 extent, with the type of problem referred.

5 MISS CARPENTER: And further, additional
6 consultations for the same patient, about how long would they
7 average?

8 DR. HODDINOTT: Of my own time spent working
9 on material, approximately 90 minutes, two hours as well.

10 MISS CARPENTER: Two hours?

11 DR. HODDINOTT: Approximately the same length
12 of time that you would spend with a patient you would have to
13 spend with the material you gathered as a result of your
14 contact with the patient. Again this varies widely depending
15 on the type of investigation required and it depends on what
16 you are attempting to do. If this is the treatment, or remedial
17 program you are carrying out, it would be more time spent with
18 the patient and less time spent working on the material by
19 yourself.

20 MISS CARPENTER: If this were included, would
21 this plan be billed with, say, \$25.00 per an initial consulta-
22 tion fee, and then for ongoing \$15.00, so it would be \$30.00
23 if it were a two-hour consultation?

24 DR. HODDINOTT: No. The initial consultation
25 -- mind you, these are the minimum recommendations.



1 MISS CARPENTER: I assume the minimum would
2 remain \$25.00 for initial consultation and \$15.00 for subsequent
3 consultations?

4 DR. HODDINOTT: Yes.

5 MISS CARPENTER: No matter, for patient hours?

6 DR. HODDINOTT: That is right.

7 MISS CARPENTER: It might be more than \$15.00
8 per patient billed to the plan? It might be more than \$15.00?

9 DR. HODDINOTT: If we require to see him once
10 a week for ten weeks at an hour a time, I imagine so.

11 MISS CARPENTER: If it were two hours at a
12 time you would be billing \$30.00?

13 DR. HODDINOTT: Be very unlikely in subsequent work
14 with the patient one would spend more than an hour at one time.

15 MISS CARPENTER: The other question in my mind,
16 the question has been raised in some circles as to whether a
17 fee for service basis is the best way to pay professional
18 workers, and I was wondering whether you had any comment about
19 this. The majority of your workers now are salaried. Do you
20 perceive the majority of your workers in private practice in the
21 future? What are the advantages or disadvantages of the two
22 payment systems?

23 DR. HODDINOTT: I don't think this is a
24 question on which the Psychological Association has a firm
25 opinion. Their concern has been certainly that salaries or



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1 fees for service at an adequate level be provided to attract
2 people into the field.

3 I don't think it would be an issue within the
4 Association whether they would be paid on a basis of fee for
5 service or on a flat consultative rate for a block of time,
6 or in fact on a salary basis. I think there has been no major
7 issue.

8 MISS CARPENTER: Is there a shortage now of
9 psychologists for the kind of work psychologists are being
10 asked to do now?

11 DR. HODDINOTT: There is a serious shortage.
12 This is a spotty shortage. As you can imagine, staff tend to
13 go where the job satisfaction and the rate of pay are adequate
14 and the tendency has been to blame the lack of psychological
15 service on shortages of personnel which is not entirely true.
16 There is a shortage, but in certain areas inadequate working
17 conditions create a serious problem.

18 MISS CARPENTER: Thank you. I think that is
19 all I have.

20 THE CHAIRMAN: I would like to follow up one
21 question Miss Carpenter asked relative to salaries. There
22 would appear to be a wide variation in salaries paid by the
23 Provincial Institution and those paid by the Universities to
24 psychologists. If I am correct in this, there would be a great
25 deal of difficulty in attracting people to a Provincial



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24 Provincial Institutions and those paid by the Universities to
25 psychologists. If I am correct in this, there would be a great
26 deal of difficulty in attracting people to a Provincial



1 Institution where psychologists are employed. How are they
2 able to get these variations, which are quite wide there?

3 DR. HODDINOTT: I provided information to you on
4 the salary scale. I think, to some extent this is misleading.
5 The answer is the Institutions do not have staff in the
6 Provincial Hospital Service itself. I have some statistical
7 information for you. We consider mental retardation as a
8 problem which requires psychological assessment. Before attempt-
9 ing to train mentally retarded children and adults, you must
10 assess their capacities. The three training schools, the
11 three hospital schools in the Province are located at Cedar
12 Springs, Orillia and Smith's Falls. The end of October 1963
13 this was a patient population of 6,646 patients.

14 There was not one psychologist trained on a
15 level to provide any service to this population.

16 THE CHAIRMAN: I think if their top salary
17 is only in the neighbourhood of \$8,000.00, which is less than
18 an Associate Professor in most of the Universities makes, it is
19 understandable that they would have difficulty in getting
20 people. The Universities are looking for good people too.

21 DR. HODDINOTT: I should stress that I have
22 given you the salary range of people with Doctorates. The
23 salary range with Master of Arts in Psychology who is
24 acceptable to some type of psychological practice is consider-
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1 THE CHAIRMAN: You don't see very many at the
2 Associate Professor level, and certainly at the Professor level
3 that do not have their Ph.D. Thank you. Mr. Caswell?

4 MR. CASWELL: I was interested in your
5 suggestion there are about 100 graduates a year now and within
6 the next few years this will double. Where is the demand for
7 extra psychologists and what is making this that attractive that
8 the number will double? Government Institutions, which
9 apparently are one of the largest employers, are not paying
10 attractive salaries. What is encouraging people to go into
11 psychology? Why is it there are so many more going to take
12 this course?

13 DR. HODDINOTT: There are other institutions
14 in addition to Government Institutions, of course. Boards of
15 Education, Workmen's Compensation Boards; Universities themselves
16 which certainly desperately need teachers. There is, in fact
17 some drift to the United States largely because of higher
18 salaries. Certainly the increase of 100 per year will in no
19 way meet the demand.

20 DR. MacMILLAN: There is also a growing demand
21 for psychologists in industry, in counselling services. At the
22 Couchiching Conference, which was held in November on counsell-
23 ing and guidance, the delegates from across the country agreed
24 that there was a very serious shortage of qualified people for
25 guidance and counselling work in schools, Boards of Education

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1 and in their own facilities, so that there will be increasingly
2 greater opportunity and resultant higher salaries in this area.

3 MR. CASWELL: In an institution like the
4 Retarded Childrens' Training Schools or Ontario Hospitals, they
5 have on their staff one psychiatrist and one psychologist?

6 DR. HODDINOTT: They would hope to have.

7 MR. CASWELL: They should have, in other words?

8 DR. HODDINOTT: I certainly think so.

9 MR. CASWELL: And you say there are, as far as
10 you know, no psychologists in the three Retarded Childrens'
11 Training Schools?

12 DR. HODDINOTT: I should make this clear. There
13 is psychological staff. These are a number of people who have
14 Bachelors degrees in Arts from Universities. They perform some
15 psychological functions. Certainly at the moment this group of
16 people under the Psychologists' Registration Act would not be
17 allowed to offer any service to the general public.

18 MR. CASWELL: What I am interested in particular-
19 ly is that in the North Bay Ontario Hospital, it has been
20 rumoured, with very good grounds, on several occasions that
21 there is a likelihood of the hospital closing because of not
22 being able to get staff I understand of psychologists and
23 psychiatrists. Now is this because of the shortage of
24 psychologists and psychiatrists, or is it because of the salary
25 scale?



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1 DR. HODDINOTT: Perhaps I can answer the
2 question in this way: There is a shortage. The turnover rate
3 in psychologists in the Ontario Hospital System as far as the
4 Association can determine it, we have been informed about this,
5 is approximately 40% per year. Now in spite of the shortage,
6 if steps could be taken to reduce the turnover, in a very short
7 period of time you would double the number of psychologists
8 available.

9 MR. CASWELL: It seems to me that your
10 Association should be able to meet with the Health Authorities
11 and find out, get to the bottom of this. There is a very large
12 institution, one of the largest in the Province which may well
13 close because of lack of staff, psychologists and psychiatrists.
14 I believe there is only one either psychologist or psychiatrist
15 there now. Now if there is a reasonable number of psycholog-
16 ists, as you suggest, and certainly the psychiatrists gave us
17 that impression also, there must be something drastically wrong
18 here that they cannot keep staff; 40% turnover. This is one
19 thing that is concerning me.

20 The other one, I am just making a comment on
21 this, is that if the majority of psychologists are working in
22 Universities, in industry, in Ontario Institutions, if the
23 need in those areas is growing, if they are being paid on a
24 salary basis by the institutions, how much need is there going
25 to be for them to be included under this Act in any case because

DR. KOPPEL: Perhaps I can answer the

is approximately 40% per year. Now in spite of the shortage,
it steps could be taken to reduce the turnover, in a very short
period of time you would double the number of psychologists
available.

MR. GARDNER: It seems to me that your

and find out, get to the bottom of this. There is a very large
institution, one of the largest in the Province which may well
close because of lack of staff, psychologists and psychiatrists.
I believe there is only one either psychologist or psychiatrist
there now. Now if there is a reasonable number of psycholog-
ists, as you suggest, and certainly the psychiatrists have as
that impression also, there must be something drastically wrong
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thing that is concerning me.

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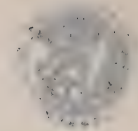
1 their patients are not, in effect, private patients? They are
2 company responsibility, or Board of Education, Universities or
3 Ontario Institutions. It would seem to me the percentage,
4 therefore, who are getting private attention is going to be
5 small. Perhaps it is not so important.

6 DR. HODDINOTT: As I understand, the present
7 official policy of the Mental Health Division, Department of
8 Health is they intend to change this state of affairs, to
9 transfer as far as possible all the responsibility for
10 psychological and psychiatric care to local community hospitals
11 and clinics. Now of course if this occurs, and it is beginning
12 to occur in a number of places, the old Ottawa Sanitorium in
13 Ottawa, for example, this will certainly change the situation
14 where clinical services are rendered by employees of the
15 Department of Health.

16 MR. CASWELL: In other words, they will not be
17 rendered by employees of the Department of Health?

18 DR. HODDINOTT: That is right. They may be
19 rendered either by a staff psychologist in general hospitals or,
20 more likely, by people who now are engaged extensively in private
21 practice.

22 MR. CASWELL: If it is true that this is their
23 intention, this, it would seem to me, would be something that
24 we should know. Because of the basis of the present tariff it
25 would seem to me it is not too important to be included, but



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1 if the Government are going to relieve themselves of this
2 present responsibility, shall we say, place hospitals under
3 private psychologists on a fee basis, perhaps there is a greater
4 need for consideration.

5 DR. HODDINOTT: Certainly, as I understand it,
6 this is the Government's policy and this is beginning to
7 operate in a number of settings. Certainly I have heard the
8 statement there will be no more mental health division, mental
9 health clinics. These will have to be community clinics,
10 supported in part by Provincial money or created by the
11 community itself.

12 MR. CASWELL: You are suggesting that this
13 would cost, as far as you know through your Association, in
14 the neighbourhood of \$3,000,000 to include this in medical
15 insurance. You are suggesting that it would be covered by
16 this. That is what I mean. It would take about that much money.

17 DR. HODDINOTT: Again the plan in the entire
18 mental health field is not very concrete. It would depend,
19 to a considerable extent, on the type of organization, the
20 service followed. Psychological services are already covered
21 by Workmen's Compensation Board facilities, for this type of
22 organization which is not normally considered health money.

23 MR. CASWELL: What I am thinking is if it would
24 cost \$3,000,000 a year to include your services, certainly
25 couldn't include the psychologist service without psychiatric

need for consideration.

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cost \$3,000,000 a year to include your services, certainly

wouldn't include the psychologist service without psychiatric



1 service so you have got another \$3,000,000 or \$4,000,000. there.

2 Thank you very much Mr. Chairman.

3 THE CHAIRMAN: Dr. Hamilton?

4 DR. HAMILTON: Thank you Mr. Chairman. Could
5 you please tell me - on page 4, paragraph 5 you state that
6 40% of the 750 people in Ontario carrying out psychological
7 work are engaged in clinical practice in mental and general
8 hospitals and in clinics. Now in the mental hospitals they
9 were paid by the Provincial Government. Please tell me how
10 they are paid in general hospitals and mental clinics?

11 DR. HODDINOTT: It depends a great deal on the
12 nature of the hospital and the clinic. I can tell you the types
13 of models that are used by psychologists engaged in this kind of
14 work. In some clinics and in some general hospitals they are
15 salaried employees of the Department of Health.

16 DR. HAMILTON: Of the Province of Ontario?

17 DR. HODDINOTT: That is right. This is a
18 situation which, I understand, is stopping in a number of
19 hospitals and clinics. They are salaried employees of the
20 hospital or that clinic.

21 DR. HAMILTON: Do you know where the hospital
22 gets their salary?

23 DR. HODDINOTT: I assume a substantial portion
24 of it is provided by the Provincial Government under Dominion-
25 Provincial Mental Health arrangements.



Thank you very much Mr. Chairman.

MR. HAMILTON: Thank you Mr. Chairman. Could

you please tell me - on page 4, paragraph 5 you state that
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1 DR. HAMILTON: Do you know whether it is paid --
2 you say under Provincial-Dominion health arrangements. There
3 are several arrangements. I am interested in knowing whether
4 you know whether the psychologists are paid with funds derived
5 from the Ontario Hospital Services Commission?

6 DR. HODDINOTT: In some cases they certainly
7 are.

8 DR. HAMILTON: Or whether they are supported
9 by a fund for research through the Mental Health branch in
10 hospitals?

11 DR. HODDINOTT: To my certain knowledge both
12 models are used.

13 DR. HAMILTON: I see.

14 DR. HODDINOTT: There is a great complexity in
15 the type of arrangements used.

16 DR. HAMILTON: You are quite sure that some
17 psychologists are employed by the hospital and their salaries
18 derived from the Ontario Hospital Services Commission?

19 DR. HODDINOTT: That is right.

20 DR. HAMILTON: Thank you. Now could you tell
21 me please, I note that under the Psychologists Registration Act
22 "No person who holds a certificate of registration shall treat
23 any person for any type of mental disorder, except at the
24 request of or in association with a duly qualified medical
25 practitioner". Do the psychologists engaged in private practice

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DR. HAMILTON: Thank you. Now could you tell

me please, I note that under the Psychologists Registration Act

"No person who holds a certificate of registration shall treat



1 have individuals consulting them directly?

2 DR. HODDINOTT: Yes. I think that this turns,
3 to some extent, on the definition of treating a mentally ill
4 person and it would be acceptable, as I understand it, both to
5 the Board of Examiners who administer the Registration Act,
6 and to the Association that certain types of problems -- to give
7 you an example, this under-achievement in school, problems of
8 this type would go to psychologists directly.

9 There are a majority of cases, however, this is
10 done on a referral from a licenced physician largely because
11 this is preferred by the psychologist. There would be cases
12 in which people would go to the psychologist directly. It is
13 quite likely most of these cases he would refer to a physician
14 with whom he is associated for a medical examination.

15 DR. HAMILTON: He might have the clientele
16 that goes directly to him?

17 DR. HODDINOTT: That is right.

18 DR. HAMILTON: Thank you very much.

19 THE CHAIRMAN: Mr. Major?

20 MR. MAJOR: Gentlemen, one thing that is
21 bothering me a little bit is the fifty cents per person per
22 year and I gather from your answers and from what you said in
23 your brief that at the present time there is a relatively small
24 number of people in the private practice of psychology; that
25 there would be very few referrals to these people from the

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1 medical profession. I say that because of your statement that
2 most of the referrals go to somebody that is on salary in an
3 institution, in a hospital, because they would most likely be
4 known to the profession better than a psychologist out on
5 Danforth East, and so on, so that the psychologist presently
6 in private practice is doing most of his work without medical
7 referral. Is this a reasonable assumption?

8 DR. HODDINOTT: No. I certainly could not say
9 that. I would say exactly the opposite. Most psychologists
10 currently in private practice work closely with the profession,
11 the physicians, and that the normal method of operation in
12 private practice is a referral from a physician. This would
13 not necessarily be always so.

14 MR. MAJOR: Let us talk of a rule of thumb
15 basis so we won't get mixed up with individuals. What percentage
16 of his practice would be from -- this is the man in private
17 practice, not on a salary basis in an institution, but with a
18 private practice -- what would his percentage be of professional
19 referrals?

20 DR. HODDINOTT: I would assume professional
21 referrals would be something of at least 85%.

22 MR. MAJOR: If we assume that for the moment
23 \$15,000.00 a year would be a reasonable salary for a man in
24 private practice, a reasonable income, if you are going to
25 graduate twice as many people in the next, per year, in the

1 medical profession. I say that because of your statement that
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22 \$15,000.00 a year would be a reasonable salary for a man in
 23 private practice, a reasonable income, if you are going to
 24 have twice as many people in the next, per year, in the



1 next five years that you have graduated in the past and there is
2 a method set up whereby some authority would pay for private
3 practice of psychologists, would not this augment the private
4 practice of psychology greatly because \$15,000 a year is only
5 200 men in private practice to eat up the \$3,000,000?

6 DR. HODDINOTT: The figure of 50 cents was
7 arrived at by assuming that the responsibility for private
8 psychological service was going to be transferred to the local
9 community and this, of course, is not limited to 50 cents a year,
10 20 people engaged in full time practice. This was an attempt
11 to realistically assess the cost to the community of carrying
12 out in the community the psychological services that currently
13 are supposed to be provided within the Ontario Hospital system.

14 MR. MAJOR: Do I get this correct? This is
15 the amount of money that is currently paid per person per year
16 whether the man is in private practice or salary?

17 DR. HODDINOTT: No. This is the Association's
18 estimate of the cost of providing in the community adequate
19 psychological service.

20 MR. MAJOR: On a private practice basis?

21 DR. HODDINOTT: On a fee for service basis.

22 MR. MAJOR: Okay.

23 DR. HODDINOTT: Now the 100 graduates per year,
24 of course does not represent the size of the group that can
25 enter private practice in the community. Under the Psychologist



1 next five years that you have graduated in the past and there
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23 DR. HODDINOTT: Now the 100 graduates per year.

24 of course does not represent the size of the group that can
25 private practice in the community. Under the psychological



1 Registration Act you cannot be a registered psychologist without
2 a Ph.D., plus one year's experience. This restricts this group
3 of 100 graduates a year to perhaps 20 and some of the 20
4 undoubtedly will be directed towards Universities.

5 MR. MAJOR: I follow you.

6 DR. HODDINOTT: And, therefore, it is not a
7 case of a large number in absolute terms practicing in the
8 community privately.

9 MR. MAJOR: That answers one aspect of it.
10 Thank you. The other one is that if the salary you quote, if
11 we can get a fee for service paid, that the same authority can
12 pay on a fee for service basis, wouldn't you draw a lot of
13 these people suddenly from their salaried position and have
14 them go into private practice?

15 DR. HODDINOTT: I don't think they can go
16 much more suddenly than they are going now. Of the total
17 psychological staff in the Mental Health Division at the moment,
18 only 20% have been with the Division longer than five years.
19 20% of the total staff. We are not certain of the average
20 length of service because this study has not been made available
21 to us. Our best estimate suggests the average person joining
22 the Hospital Service stays perhaps eighteen months. I think
23 no provision of an adequate fee for service can produce much
24 more of a shock than this.

25 MR. MAJOR: In other words, at the present time



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1 you do not feel that there is any deterrent to the private
2 practice of psychologists because the patient has to pay the
3 bill himself? This is not a deterrent to the business of
4 private practice of psychology?

5 DR. HODDINOTT: I would say no, not at the
6 moment.

7 MR. MAJOR: And at the present time the demand
8 is heavy enough to overcome all these deterrents at the present
9 time?

10 DR. HODDINOTT: I think so, yes.

11 MR. MAJOR: And then in your considered opinion
12 this \$3,000,000 is a reasonable estimate then for the fore-
13 seeable future of the next three or four years?

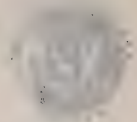
14 DR. HODDINOTT: Yes, certainly.

15 MR. MAJOR: Thank you. That is all Mr.
16 Chairman.

17 THE CHAIRMAN: Thank you. Mr. Simon?

18 MR. SIMON: Are there any insurance companies
19 now covering psychological services at all?

20 DR. HODDINOTT: There are a number. The
21 Association is not very clear about this and has Committees
22 attempting to find out. It is becoming a relatively common
23 practice in companies that insure in the United States, to
24 cover some form of psychological service. Those companies who
25 have contracts with industries that have subsidiaries here are



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17 THE CHAIRMAN: Thank you, Mr. Maynor.
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25 have contracts with industries that have subsidiaries here are



1 beginning to extend these benefits in the Province of Ontario
2 as well. I understand, although I have no definite information,
3 that under some circumstances a number of private carriers in
4 the field do offer some psychological coverage.

5 MR. SIMON: You spoke about a number of private
6 industries. Are these large companies have you any idea?

7 DR. HODDINOTT: I have no definite information.
8 I assumed that they would be of a fair size.

9 MR. SIMON: Have you any idea that psychological
10 services are being covered in the State health plans in Great
11 Britain, Australia and so on?

12 DR. HODDINOTT: No definite information.

13 MR. SIMON: One more question: Would you care to
14 psychoanalyze this Board? It seems to me we have undertaken a
15 super-human job here.

16 DR. MacMILLAN: You can make appointments at the
17 door.

18 MR. MAJOR: Doctor, you said that there are
19 insurance companies, to the best of your knowledge, paying for
20 psychological services.

21 DR. HODDINOTT: This is perhaps too broad a
22 statement. My understanding is that for certain types of ref-
23 erral this would be covered.

24 MR. MAJOR: If this was on the referral of a
25 physician?



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1 DR. HODDINOTT: Yes.

2 MR. MAJOR: Then it becomes a benefit of this
3 particular insurance agreement?

4 DR. HODDINOTT: Yes but I think it is limited
5 further. I think it depends on the nature of the referral. My
6 understanding is that some insurance coverage covered psycholo-
7 gical service in the case of a referral for some type of brain
8 damage where the neurologist or the physician wanted to get
9 some estimate of the capacity of the patient remaining to him
10 or the extent of the deficit suffered. This could be
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1 MR. NAYLOR: You indicated that your services
2 include guidance counselling. I suppose there are certain
3 other things -- marriage counselling, perhaps, which are perhaps
4 not directly related to the health of the individual or mental
5 or emotional disturbances. I guess they would be indirectly
6 related. Are you requesting that the plan should provide pay-
7 ment for all of your services?

8 DR. MacMILLAN: No. Perhaps I can clarify this
9 by saying that the Ontario Association is interested in all
10 psychological services. There are four major areas: The
11 counselling and guidance field, the industrial field, educational
12 field and the clinical field. The one we are most concerned
13 with here is the clinical field, where there would be some
14 evidence of mental illness, in which referral from a physician
15 is indicated and the service is provided on this basis.

16 In industry, for example, where I work I have
17 very little contact with clinical patients. If we do have a
18 case that shows evidence of mental disturbance, I would refer
19 him to our medical department to a psychiatrist or to a
20 psychologist.

21 MR. NAYLOR: What would be a practical way of
22 making the distinction? Would it be that we should consider
23 payment only where there is referral by a physician? Would
24 that be a practical way to do it, or have you any suggestion
25 on that?



MR. WAYNE: You indicated that your services

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1 DR. HODDINOTT: I would suggest this would
2 work. I think the Association would be uneasy about this, but
3 I think they would be prepared to accept it.

4 I think there are other ways, but one of the
5 difficulties with referral through a physician is that in a
6 number of cases this is not a model which is currently in
7 operation and frequently the situation in, say, a Childrens'
8 Aid Society would be that the Childrens' Aid Society would
9 refer the child to the consulting psychologist and obtain an
10 opinion to see whether the child should be referred to
11 psychiatric help. Models exclusively organized on the basis
12 of a referral from a medical practitioner has to reverse this
13 process.

14 THE CHAIRMAN: Can you give me an example, in
15 layman's language, of the situation existing with a patient
16 where a psychiatrist would refer him to a psychologist for
17 either examination or treatment?

18 DR. HODDINOTT: There are a very large number
19 and this depends to a great extent on the psychiatrist's own
20 preferences in the matter. Perhaps the most commonly accepted
21 situation would be the medical practioner's suspicion that the
22 case he was seeing had a component that might be related to
23 brain injury. Under those circumstances, it would probably
24 be universally agreed this should be referred to a psychologist
25 for an assessment.

MR. HODGKINS: I would suggest this would

work. I think the Association would be uneasy about this, but

I think they would be prepared to accept it.

I think there are other ways, but one of the

difficulties with referral through a physician is that in a

number of cases this is not a model which is commonly in

operation and frequently the situation in, say, a California

Aid Society would be that the Children's Aid Society would

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1 THE CHAIRMAN: What is the difference in
2 education or training of the psychologist and the psychiatrist
3 that makes it desirable for such a patient to be treated by a
4 psychologist rather than a psychiatrist?

5 DR. HODDINOTT: The psychologist would special-
6 ize in -- his training would require definite skills in the
7 assessment of cognitive and perceptual functioning, which would
8 reflect brain damage. This would be provided in the medical
9 training of the psychiatrist with nowhere near the intense and
10 theoretical level that it would be in the training of a
11 psychologist.

12 MR. MAJOR: Can I follow that up?

13 DR. BUTT: Can I pursue this.

14 THE CHAIRMAN: I think Dr. Butt was the first
15 and then we will call on you, Mr. Major, and Dr. Galloway.

16 DR. BUTT: I am particularly concerned when you
17 say you follow injury with psychological testing?

18 DR. HODDINOTT: That is correct.

19 DR. BUTT: What would this consist of, from
20 your standpoint?

21 DR. HODDINOTT: An extensive battery of
22 psychometric instruments, certainly covering the visual-motor
23 areas, perhaps testing the speech function, testing the
24 retention and this type of material.

25 DR. BUTT: Could this be confused with other

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1 psychological impairments; in other words, on the psychotic
2 side, or something like this, having to do with actual brain
3 injury or brain tumour?

4 DR. HODDINOTT: Not in the hands of the skilled
5 practitioner. He would be capable of differentiating the type
6 of pattern. I am not suggesting that this would be a routine
7 referral from a psychologist. This is a question of a suspicion
8 on the part of a medical specialist that this process may be
9 involved and he has either had contradictory evidence or no
10 evidence from, perhaps, an electroencephalogram.

11 DR. BUTT: What about a carotid angiogram?
12 Would you say that your test would produce some evidence of
13 what is going wrong in a carotid angina, or a neuro-encephalo-
14 gram, or those tests that are commonly accepted for this type
15 of thing?

16 DR. HODDINOTT: I am not making myself clear.

17 DR. BUTT: Are you saying that this is the way
18 to test it, rather than these other accepted processes?

19 DR. HODDINOTT: No. I am suggesting that
20 although it was a psychological test and perhaps an electro-
21 encephalogram will give evidence related to the presence or
22 absence of this type of damage, the electroencephalogram is
23 not going to be very helpful to the practitioner in assessing
24 the level of functioning left to the patient in the visual and
25 speech areas, and the psychological test is. One certainly is



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motor areas, and the psychological test is. One certainly is



1 not a substitute for the other.

2 DR. BUTT: In other words, it is one aid in
3 arriving at organic disease?

4 DR. HODDINOTT: That is correct.

5 DR. BUTT: And, as such, it is a technical
6 procedure in that level? In other words, you haven't a total
7 assessment from the psychological test to arrive at a diagnosis?

8 DR. HODDINOTT: Again, it depends on what is
9 implied by "total assessment". An x-ray is a technical
10 procedure.

11 DR. BUTT: Correct.

12 DR. HODDINOTT: I do not think a radiologist
13 would say he is a technician. The x-ray produces material in
14 a technical way which then requires his considerable skill to
15 interpret.

16 DR. BUTT: So does an electroencephalogram.

17 DR. HODDINOTT: Yes.

18 DR. BUTT: What I am trying to say is that
19 the establishment of a diagnosis and the treatment of a
20 disease cannot be done on just your psychological areas?

21 DR. HODDINOTT: No, of course not. The
22 Association would not suggest this.

23 DR. BUTT: What other fields, clinical fields
24 do you cover besides psychological testing?

25 DR. HODDINOTT: Certain treatment.

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do you cover besides psychological testing?

DR. HODDINOTT: Cerebral treatment.



1 DR. BUTT: What types?

2 DR. HODDINOTT: Psycho-therapy.

3 DR. BUTT: Psychoanalysis?

4 DR. HODDINOTT: Unless you are a trained
5 analyst, no, but potentially, of course, a psychologist might
6 be.

7 DR. BUTT: Comparable to the psychiatrist?

8 DR. HODDINOTT: In the field of psycho-therapy.

9 DR. BUTT: This is what you wish to do?

10 DR. HODDINOTT: This is what the Ontario
11 Government currently says we do.

12 DR. BUTT: It is not what you are allowed to
13 do, according to Section 12 of the Registration. It specific-
14 ally excludes this, as I understand it?

15 DR. HODDINOTT: No. It specifically includes
16 it, provided the patient is referred by a physician.

17 DR. BUTT: All right -- a moot point. But you
18 want to treat patients coming directly to you as well?

19 DR. HODDINOTT: I do not suggest this.

20 DR. BUTT: But your previous statement indicated
21 that you do not want it to be by appointment?

22 DR. HODDINOTT: No. There are certain types
23 of patients who are probably not mentally ill, as defined
24 legally, who do go to psychologists privately, without referral.
25 I doubt whether you would say the procedure you follow in

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1 regard to those patients is psycho-therapy.

2 THE CHAIRMAN: Mr. Major?

3 MR. MAJOR: My question has been answered.

4 THE CHAIRMAN: Dr. Galloway?

5 DR. GALLOWAY: I think mine has been answered
6 too, Mr. Chairman, except I would like you to discuss a little
7 further, and I am sure this is what has been bothering this
8 Committee. We can all appreciate your role in the abberations
9 from normal and the assessments which you do to help establish
10 a diagnosis. I think that we are concerned because through
11 your brief is this trend towards therapy or discussion of
12 therapy and it is the part of the psychologist in the actual
13 treatment of the patients that is of some interest and
14 concern to us, both from what your treatment is and the poss-
15 ibility of insuring it. What percentage of the people would
16 you be treating and for what length of time and how do you go
17 about it?

18 DR. HODDINOTT: We are not sure, in the space of
19 time available to us here that we can be a great deal of help.
20 I think I can suggest this. A very common concern between
21 psychologists and pschiatrists is the question of treatment
22 of mental disorder and who is entitled to treat this.
23 Psychologists and other non-medical groups would prefer, I
24 think, to deal with this question entirely in terms of who is
25 trained to treat the mentally ill. For very good reasons, my

regard to those patients is psycho-therapy.

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trained to treat the mentally ill. For very good reasons, my



1 experience with my colleagues in the medical profession, they
2 would prefer to deal with this question in terms of who is
3 licenced to treat anyone. The Registration Act was arrived at
4 with close collaboration with the Ontario Medical Association,
5 the Ontario Psychiatric Association and the feeling was that
6 a middle ground had been found and that was for groups of
7 people who could be termed legally mentally ill, registered
8 psychologists would not treat those, except in association
9 with the licenced practitioner, or at the request of a licenced
10 practitioner. I would assume that any physician behaving
11 ethically, would want to know, in terms of his referral,
12 what the likely treatment procedures psychologists might
13 undertake would be. Many of these, chemo-therapy, electro-
14 shock, are not in question because these are not within the
15 licenced powers of the psychologists. In the practical opera-
16 tion of psychological services, as far as I know, though there
17 has been considerable apprehension, there has been no
18 difficulty in solving this as a problem. Most people in
19 private practice, and in my own case with a very limited
20 amount of private work that I do, customarily have patients
21 referred to us, usually by psychiatrists. This is a close
22 team relationship that develops.

23 I would say that if you wanted to list the
24 types of therapy which a psychologist might do, these would
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1 trained, certainly behaviour therapy, reciprocal emotion
2 therapy. We can go on. Possibly under the terms of the Bill
3 relating to hypnosis, hypno-therapy.

4 DR. GALLOWAY: Do you do hypno-therapy?

5 DR. HODDINOTT: Certainly not personally.

6 DR. BUTT: Is hypnosis accepted in Ontario?

7 DR. HODDINOTT: Its use is closely regulated
8 by law at the present time.

9 DR. GALLOWAY: In the treatment of the truly
10 mentally ill, you are ancillary to the psychological services;
11 but in variations of normal, you are separate from and act
12 independently of the psychiatrist?

13 DR. HODDINOTT: I think even the word
14 "ancillary", unfortunately, gets emotional connotations. I
15 would say that psychological services were ancillary
16 psychiatric services if the Act read "under the direction of".
17 Fortunately, it does not read in that way. It says "Under the
18 supervision of or in association with". And I think where a
19 licenced physician and psychologist work together in associa-
20 tion, it is not a fair statement to say that this would be
21 ancillary service.

22 DR. GALLOWAY: You have answered the question
23 very well and thank you. Except for one thing -- what
24 percentage of the private practice would be in the therapy
25 aspect?



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1 DR. HODDINOTT: I would think this would be
2 impossible to estimate accurately. My guess would be that
3 this is somewhere in the region of 30%.

4 DR. GALLOWAY: Thank you very much.

5 DR. HODDINOTT: But this is very much a guess.

6 MR. WHITNEY: On page 7, you quote Section 12
7 of the Registration Act and I am still not clear on the question
8 that was raised by Mr. Naylor and followed through the
9 discussion here. In reading that section, the principal word
10 there seems to be "treat" and I presume that means much what
11 Dr. Galloway was touching on. Do you read that that that
12 restricts you in the area of treatment to cases only on
13 referral? In other words, are you confined strictly to
14 referral work from a physician or in association with a
15 physician when you are in the treatment area?

16 DR. HODDINOTT: Provided this is a type of
17 mental disorder.

18 MR. WHITNEY: Yes. I can see that is the
19 qualification. Then you do do work on a direct basis where
20 you are treating, where it is not a mental disorder?

21 DR. HODDINOTT: Yes. I think that this
22 becomes semantically very difficult. All of the social science
23 professions have never been able to define, legally, the term
24 "psycho-therapy". It is a face-to-face contact with another
25 person. If you restrict the practice, this type of practice,



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1 what do you do about a minister or priest who does marriage
2 counselling? This is the type of dilemma that all the
3 professions are confronted with all the time.

4 MR. WHITNEY: No. This is fee business, isn't
5 it?

6 DR. HODDINOTT: Yes.

7 MR. WHITNEY: There is also the word "fee"
8 in here?

9 DR. HODDINOTT: I am aware in some cases of
10 centres sponsored by religious groups for marriage counselling
11 which charge fees. They are a non-profit centre, but they
12 still charge a fee.

13 MR. WHITNEY: There are such places?

14 DR. HODDINOTT: Certainly in North America
15 there are. I am not sure there are any locally in Toronto
16 that I know of. There would be nothing illegal at the moment
17 for someone with no training whatsoever, who was interested,
18 had a grade 6 education, for setting up in business as a
19 marriage counsellor and seeing couples with marriage problems,
20 for a fee.

21 MR. WHITNEY: Aren't we getting quite aways
22 away from psychology, though?

23 DR. HODDINOTT: What I am trying to suggest
24 is that there are human, inter-personal problems, such as
25 marital problems, which a psychologist might treat, but which



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2 disorder and it is in these areas that he would treat without
3 a referral from the practitioner, or could treat without a
4 referral. Experience suggests that in fact even in those areas
5 where it is not legally necessary to have the person referred,
6 most of the referrals still come from a licenced pratitioner
7 because he is likely to encounter them first.

8 MR. WHITNEY: Thank you.

9 THE CHAIRMAN: This being an Act, Section 12
10 of the Act that was referred to here, presumably if the
11 psychologist treated a person for fees and that person had
12 not been referred to him and he treated him on the assumption
13 that it was not a mental disorder that he was treating, it
14 was later proved that it was a mental condition, what action
15 can be taken against the psychologist?

16 DR. HODDINOTT: The potential immediate action
17 would be that this would become the subject of complaint to the
18 Ontario Board of Examiners and Registration who administer the
19 Registration Act, and they can suspend the Registration.

20 THE CHAIRMAN: How could they determine whether
21 it was a mental condition or whether it was not? Isn't there
22 a borderline here? I am not trying to trick you now. Isn't
23 there a borderline here where it is very difficult to tell
24 whether this is actually a mental condition or whether it is
25 not a mental condition? Let us take a child who is not



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1 progressing satisfactorily at school, much below the average,
2 and if the school teacher suggests to the parents that this
3 child should go to a psychologist, it could be a mental
4 condition, possibly, couldn't it or it could not be. How do
5 you determine, when you start treating, or examining a child,
6 whether it is or it is not?

7 DR. HODDINOTT: I think this is a matter for
8 the individual's professional judgment. I agree it is very
9 difficult to determine in a small number of cases and I take
10 it that if this went before the Board of Examiners, they would
11 simply have to call expert witnesses to determine as accurately
12 as possible.

13 THE CHAIRMAN: Well, if in the opinion of the
14 psychologist it was a mental condition, before the psychologist
15 would begin to treat that child, he would then refer the child
16 to the physician for, again, referral back to him for treatment?

17 DR. HODDINOTT: That is right, if the physician
18 chose to do so.

19 THE CHAIRMAN: So if this were included,
20 referrals should be quite acceptable then?

21 DR. HODDINOTT: I think so.

22 THE CHAIRMAN: Are there any other questions
23 from the Committee?

24 MR. MULROONEY: The brief tells us that
25 psychologists are working with mentally retarded children in



progressing satisfactorily at school, much below the average,
and if the school teacher suggests to the parents that this
child should go to a psychologist, it could be a mental
condition, possibly, couldn't it or it could not be. Now do
you determine, when you start dressing, or examining a child,
whether it is or it is not?

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THE CHAIRMAN: Are there any other questions?



1 the Ontario Hospital School. Can you tell us whether payment
2 for the psychological services comes through the Department of
3 Education, School Boards, or is this borne by the Ontario
4 Hospital Services Commission?

5 DR. HODDINOTT: To the best of my knowledge,
6 it is not borne by the Ontario Hospital Services Commission.
7 The Act is very peculiar in the sense that for admission to the
8 Ontario Association for Retarded Children Schools, which are
9 supported by grants from the Department of Education, a child
10 must be tested psychologically and must have an intelligence
11 quotient of 50 or less. There is no provision made for the
12 provision of this type of service; so, the community is forced
13 to fall back on whatever sources are available to it. In some
14 cases these are the private practitioner and in some cases the
15 general hospital -- whatever the financial model is in the
16 hospital. In many cases, it is the Ontario Department of
17 Health resources available in the community.

18 MR. MULROONEY: You mentioned a number of
19 children mentally retarded, the 6,446; can you tell us whether
20 this is the total number of children in the Province who
21 require or should have this type of treatment or are there
22 many more? Is there any estimate of the number who need this
23 type of test?

24 DR. HODDINOTT: There would be a tremendous
25 number that could profit from psychological services. I think



the Ontario Hospital School. Can you tell us whether payment for the psychological services comes through the Department of Education or through the Ontario Hospital Association?

DR. HODGKINS: To the best of my knowledge, it is not borne by the Ontario Hospital Services Commission. The Act is very peculiar in the sense that for admission to the Ontario Association for Retarded Children Schools, which are supported by grants from the Department of Education, a child must be tested psychologically and must have an intelligence quotient of 50 or less. There is no provision made for the provision of this type of services; so, the community is forced to pull back on whatever services are available to it. In some cases there are the private practitioners and in some cases the General Hospital -- whatever the financial model is in the hospital. In many cases, it is the Ontario Department of Health resources available in the community.

MR. MURPHY: You mentioned a number of children mentally retarded, the 1,400; can you tell us whether this is the total number of children in the Province who require or should have this type of treatment or are there many more? Is there any estimate of the number who need this

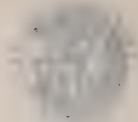
DR. HODGKINS: There would be a tremendous



1 this number, conservatively, would be 20,000. The number is
2 sufficiently large that any Board of Education of any size is
3 in the process of attempting to build up a Department which can
4 provide psychological services. In the City of Toronto, the
5 Director of the Child Testing Services has a staff of
6 approximately 30 people engaged in psychological assessment
7 work. The 6500 children in the three hospital schools form a
8 group for whom at the moment of their admission, no other
9 answer was available. I haven't the figures on the number of
10 children in schools which are borne by the Association for
11 Retarded Children.

12 MR. MULROONEY: From the brief and your
13 summary, the answers and questions, I as a layman infer that
14 the psychologist is actively engaged in the treatment of
15 mental illness generally. I think the Committee would like
16 a statement. Perhaps an answer to a question would tell us
17 what I would like to know. Does the full, adequate treatment
18 of the mentally ill require the services of a psychologist?

19 DR. HODDINOTT: I think there would be no
20 disagreement at all between any of the professions about this.
21 There will be a clear statement at any level, either Government
22 or professional, that adequate facilities for the mentally
23 ill must have the involvement of the psychologist as well as
24 the psychiatrist and probably a social worker, in addition.
25 There would be no argument about this.



this number, consecutively, would be 23,000. The number is
sufficiently large that any Board of Education or any other
in the process of attempting to build up a department which
provide psychological services. In the City of Toronto, the
Director of the Child Welfare Service has a staff of
approximately 30 people engaged in psychological assessment
work. The 6500 children in the three hospitals would form a
group for whom at the moment of their admission, no other
service was available. I haven't the figures on the number of
children in schools which are being by the Association for the
Handicapped.

MR. STANLEY: From the data and group
summarily, the answers and questions. I as a lawyer follow that
the psychological is actively engaged in the treatment of
mental illness generally. I think the Committee would find
a statement, perhaps an answer to a question would tell us
Does the child, adequate treatment

of the mental ill requires the services of a psychologist
MR. STANLEY: I think there would be no
disagreement at all between any of the professions as to this.
There will be a great statement at any level, either Government
or professional, that adequate facilities for the mentally
ill must have the involvement of the psychologist as well as
the psychiatrist and probably a social worker, in addition.
Would be no argument about that.



1 MR. MULROONEY: Thank you, sir.

2 THE CHAIRMAN: Are there any other questions?

3 MR. COULTER: With regard to the schools,
4 Boards of Education, Guidance people, psychiatrists hired by
5 schools, other than on regular salary schedule, that part of
6 their salary that is a grant, that comes under the regular
7 grant that is paid by the Department of Education. So the
8 Department of Education does pay a portion of this guidance
9 salary.

10 THE CHAIRMAN: You caught me off balance here.
11 This was just a comment?

12 MR. COULTER: Yes, just a comment. Mr.
13 Mulrooney, I think, asked a question. I happen to have served
14 a number of years on the Board of Education, so I knew how
15 they were partly paid by the Department.

16 THE CHAIRMAN: Are there any other questions?

17 MR. CASWELL: I would like to congratulate the
18 gentlemen for the very fine way in which they have presented
19 their brief and answered our questions in a most informative
20 and intelligible and straightforward manner.

21 THE CHAIRMAN: Do you have anything further
22 to say, gentlemen?

23 MR. HODDINOTT: No, Mr. Chairman. Thank you.

24 THE CHAIRMAN: Thank you very much, gentlemen.

25



THE CHAIRMAN: Are there any other questions?

MR. COLEMAN: With regard to the salaries.

Board of Education, Baltimore people, representatives hired by

their salary that is a grant, that comes under the regular

grant that is paid by the Department of Education. Is the

Department of Education does pay a portion of this salary?

salary.

THE CHAIRMAN: You caught me off balance here.

This was just a comment?

MR. COLEMAN: Yes, just a comment, Mr.

Mulvaney, I think, asked a question. I haven't had time to

a number of years on the Board of Education, so I know how

they were partly paid by the Department.

THE CHAIRMAN: Are there any other questions?

MR. COLEMAN: I would like to ask a question.

Gentlemen for the very first time in which they have presented

their first and answered our questions in a most informative

and interesting and very thoughtful manner.

THE CHAIRMAN: Do you have anything to say?

no say, gentlemen.

MR. MOONSHOOT: No, Mr. Chairman. Thank you.

THE CHAIRMAN: Thank you very much, gentlemen.



1 SUBMISSION OF THE SAULTE STE. MARIE AND DISTRICT
2 GROUP HEALTH ASSOCIATION

3 Appearances: John H. Osler, Q.C., -- Counsel,
4 John G. Barker -- Chairman of the Board,
5 T.A. Ferrier, M.D., -- Medical Director,
6 Gordon Milling -- Member of the Board
 of Directors.

7 MR. OSLER: If I might introduce the delegation,
8 my name is Osler. Sitting next to me is Dr. Ferrier, the
9 Medical Director. Next to him is Mr. Barker, Chairman of
10 our Board and on the end is Mr. Milling, a member of the
11 Board of Directors.

12 THE CHAIRMAN: If you wish to proceed, as
13 you will have noticed from the instructions, we have read your
14 brief and it will not be necessary for you to read the brief.
15 If you prefer to be seated, please feel free to do so.

16 MR. OSLER: Thank you, Mr. Chairman. While
17 I have noted and will abide by your instructions, I have
18 prepared a very bald summary of our recommendations which I
19 think have been distributed to the members of the Commission
20 in the last few minutes and with your permission I would like
21 to just read that through and then we can perhaps zero in on
22 the point we are trying to make.

23 The summary of our recommendations is as
24 follows:

- 25 1. Amendment of a. 1 (1) to conclude which provide
 medical or surgical care or services, as distinct



John A. Hutton -- Chairman of the Board
Gordon Milling -- Member of the Board
of Directors

MR. CHAIRMAN: It is my pleasure to introduce the delegation

my name is Gordon. Sitting next to me is Mr. Hutton, the
Medical Director. Next to him is Mr. Hutton, Chairman of
our Board and on the end is Mr. Milling, a member of the
Board of Directors.

MR. CHAIRMAN: If you wish to proceed, as

you will have noticed from his introduction, we have read your
brief and it will not be necessary for you to read the brief.

If you prefer to be tested, please feel free to do so.

MR. CHAIRMAN: Thank you, Mr. Chairman. While

I have noted and will abide by your instructions I have

prepared a very brief summary of our recommendations which I

think have been distributed to the members of the Committee

in the last few minutes and with your permission I would like

to just read that through and then we can proceed with our

the point we are trying to make.

The summary of our recommendations is as

follows:

1. Amendment of A. I. (1) to include which provides
medical or surgical care or services, as distinct



1 from more indemnification for some or all of
2 the cost of such services.

3 1.a. Alternatively, a clear differentiation between
4 the above types of organization, with special
5 provisions applicable to the former.

6 2. Amendments to secs. 2, 11 and 12 so as to make it
7 clear that any particular organization of the first
8 type is not obliged to accept all applicants,
9 regardless of geographical location.

10 3. Eliminate, for the first type of organization,
11 responsibility to give service wherever requested."

12 We elaborate on that in the brief. When we
13 set up an organization based upon a physical plant in a
14 particular location, we cannot undertake to give service beyond
15 a reasonable geographic range that can be served from that
16 plant.

17 4. Provision for special arrangements with respect to
18 working capital in the first type of organization.

19 5. Elimination of the requirement for "standard
20 contracts", of identical nature to those provided
21 by insurers, in the case of the first type of
22 organization.

23 6. Removal of organizations providing services from
24 the jurisdiction of Medical Carriers Incorporated,
25 leaving them to be supervised either by the

from were undertaken for some or all of

the cost of such services.

1.2. Alternatively, a clear differentiation between

the above types of organization, with special

provisions applicable to the former.

2. Amendments to cases 1, 2, 3, 4 and 5 as to make it

clear that any particular organization of the first

type is not obliged to accept all provisions.

regardless of geographical location.

3. Eliminate, for the first type of organization,

responsibility to give service wherever requested."

set up an organization based upon a physical plant in a

particular location, we cannot undertake to give service beyond

a reasonable geographic range that can be served from that

plant.

4. Provision for special arrangements with a view to

working capital in the first type of organization

5. Elimination of the requirement for "standards

contracts", of identical nature to those provided

by insurance in the case of the first type of

organization.

removal of organizations providing services from

being then to be supervised either by the



1 Departments of Health and Insurance, as at present,
2 or by a separate organization formed for that purpose."

3 Now, Mr. Chairman, I think the principal point
4 in our brief and the principal submission that we would like
5 to make to this Commission is that we can see nothing at
6 variance with the principle of this Bill; that is the desire to
7 ensure that services are available throughout the Province to
8 those who need them. We can see nothing inimical to the
9 principle of the Bill and if a distinction is made between
10 insurers -- and I am using that in a very broad sense -- all
11 forms of indemnification for the cost of illness and organiza-
12 tions such as our own and many co-ops that have as their basic
13 principle the provision of service by pre-payment, without the
14 intervention of an insurer. We feel that these are two
15 alternative methods of accomplishing the object of the Bill --
16 the provision of adequate services in this Province. We feel
17 that it would be a distortion, and create great difficulty,
18 if the service type of organization must be crammed somehow
19 within the provisions of a Bill designed to deal with the
20 insurance principle because they are two different principles.
21 And we feel either that our type of organization should be
22 simply excluded from the requirements of any Act that may
23 flow from this Bill, or the various amendments should be made
24 to the Bill to recognize clearly the distinction between the
25 provision of service and the indemnification for the cost of

Now, Mr. Chairman, I think the principal point

in our brief and the principal submission that we would like

to make to this Commission is that we can see nothing at

variance with the principle of this Bill; that is the desire to

ensure that services are available throughout the Province to

those who need them. We can see nothing intrinsic to the

principle of the Bill and if a distinction is made between

insurers -- and I am using that in a very broad sense -- all

forms of indemnification for the cost of illness and organiza-

tions such as our own and many others that have as their basis

principally the provision of service of pre-payment, without the

intervention of an insurer. We feel that there are two

alternative methods of accomplishing the object of the Bill --

the provision of adequate services in this Province. We feel

that the Bill is a very good one and that it is a very

if the nature type of organization must be changed somewhat

within the provisions of a Bill designed to deal with the

insurance principle because they are two different problems

And we feel that that our type of organization would be

timely excluded from the requirements of any Act that may

flow from this Bill, or the various amendments should be made

of the Bill, or the various amendments should be made

of service and the indemnification for the cost of



1 service.

2 Now, I do not know that I can elaborate any
3 further without getting into the brief. Perhaps it would be
4 best if I made myself and the delegation available for
5 questioning on some of the matters raised.

6 THE CHAIRMAN: I assure you that there are
7 quite a number of questions that will be asked by the members
8 of the Enquiry. I do not usually start the questioning off,
9 but I will ask one for clarification at the beginning. Do I
10 understand you correctly to say that you approve of the
11 principle of the Bill, under the circumstances that you men-
12 tioned there, but indicate that you are not, or your group is
13 not, satisfied that this Bill goes far enough toward universal
14 insurance coverage?

15 MR. OSLER: I do not think I can speak with
16 authority for the Association as such. I think most members
17 of the Board are unhappy about the relatively limited nature
18 of this Bill. I do not think the coverage is going to be
19 sufficient and I think most of them would desire to see a very
20 great extension.

21 However, as a Corporation appearing here today,
22 we are not concerned with opposing the principle of the Bill;
23 we are concerned with making the strongest submission we can
24 on the point I have mentioned, that the Bill, as presently
25 drafted, lumps together insurance and insurers. We think they



1 must be dealt with separately.

2 MISS McARTHUR: I am aware that the Enquiry
3 is a group and I am aware that it has not made any decisions,
4 but I would like to say, in quotes: "I am hostile to this
5 delegation because they have answered my questions by their
6 additional submissions."

7 MR. OSLER: My brief was not clear enough;
8 perhaps I have made it a little clearer.

9 MISS McARTHUR: The thing I was trying to find
10 in my question was whether they felt that Bill 163 did not
11 permit the kind of program that they had presented to continue
12 to exist and I have a feeling that some of the additional
13 comments have answered that question. So I am completely lost.
14 I haven't a question at the moment. I may come in later.

15 THE CHAIRMAN: I wouldn't be surprised.

16 MR. OSLER: To the extent that that is a
17 question, I would, I think, not agree with Miss McArthur that
18 the principle of this Bill unchanged would make it impossible
19 for a service type of organization to exist. Our point is
20 that it would require a great deal of warping and distortion
21 and uneconomic ways of doing things if we had to squeeze
22 ourselves within the four walls of this Bill.

23 MISS McARTHUR: Fine, thank you.

24 MR. MULROONEY: I think, like Miss McArthur,
25 most of my questions have been answered. I do not know



1 whether, as far as the Committee is concerned, I should dis-
2 qualify myself. It happens that I am a Director of the Group
3 Health Association of America and, to some degree, associated
4 with the gentlemen. I think that there is one way that we
5 might solve one of their problems, assuming that they could
6 not be exempted from the Act as, in a sense, they are requesting.
7 Now, this is simply that we might undertake to assist them and
8 to underwrite for them the direct applications for the standard
9 contract for persons for whom you cannot underwrite coverage;
10 similarly, we might by agreement with you undertake to under-
11 write coverage for your members in group and this sort of
12 thing. This is a possibility that I would like you to consider.

13 MR. OSLER: Are you suggesting, do I understand
14 you, that while perhaps we would have to remain within the
15 Bill, we might be removed from compulsory membership in Medical
16 Carriers Incorporated?

17 MR. MULROONEY: No. I have not touched on that
18 -- simply the matter of underwriting coverage for any person
19 who applies for a standard contract, that by re-insurance, if
20 you like, I might help you with that problem. As far as
21 Medical Carriers Incorporated, this is another question which
22 has not yet been considered, as far as I know.

23 MR. CASWELL: It sounds like another carrier
24 promoting a little business.

25 MR. MULROONEY: I would like to say, for



1 whether, as far as the Committee is concerned, I should like
2
3
4 with the gentleman. I think that there is one way that we
5 might solve one of their problems, assuming that they could
6 not be exempted from the Act at, in a sense, they are responsible
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9 contract for persons for whom you cannot underwrite coverage
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11 write coverage for your members in group and this sort of
12 thing. This is a possibility that I would like you to consider
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14 MR. CLEGG: Are you suggesting, do I understand
15 you, that while perhaps we would have to remain within the
16 Bill, we might be removed from compulsory membership in Medical
17 Carriers Incorporated?
18
19 MR. WILSON: No. I have not touched on that
20 ... simply the matter of underwriting coverage for any person
21 who applies for a standard contract, that by re-insurance, if
22 you like, I might help you with that problem. As far as
23 Medical Carriers Incorporated, this is another question which
24 has not yet been considered, as far as I know.
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26 MR. CARWELL: It sounds like another carrier
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1 Mr. Caswell's benefit, that we are fellow co-operators here
2 and I would like to suggest that co-operators can co-operate
3 with co-operators.

4 MR. NAYLOR: I would like to make a few
5 comments first which I think will lead up to one or two
6 questions. Just speaking personally, it does seem to me
7 logical that an organization such as yours that has been set
8 up to provide medical service for a limited group of people
9 and in a limited area, might well be exempted from the
10 requirement of the Act to offer the standard plan, generally.

Mr. Caswell's benefit, that we are fellow co-operators here
and I would like to suggest that co-operators can co-operate
with co-operators.

MR. MAYLOR: I would like to make a few
comments first which I think will lead up to one or two
questions. Just speaking personally, it does seem to me
logical that an organization such as yours that has been set
up to provide medical service for a limited group of people
and in a limited area, might well be exempted from the
requirement of the Act to offer the standard plan, generally.



1 MR. NAYLOR: Also it might be reasonable that
2 you might not be limited by the maximum premiums, at least
3 directly. I think there should be some possible control to
4 see the charges that you are making, taken in total, are
5 reasonable in relation to the benefits provided as correspond-
6 ing to the maximum premium set up. Coming to your complaint
7 about Medical Carriers Incorporated, I think essentially the
8 idea of this body is to operate a taxing arrangement, and that
9 might be called a self-taxing device to which all carriers,
10 whatever type it may be, will carry the cost of private
11 insurance for high cost risks, whether they are old people
12 or unhealthy people, whatever they may be and it seems only
13 fair that every type of carrier, including your own type of
14 Association, should bear their fair share of that cost.
15 Otherwise, it would simply encourage organizations, instead
16 of taking their medical service insurance with one of the
17 carriers that was a member of the Medical Carriers Incorporated
18 and will have some small cost to bear in this connection, to
19 encourage them to set up organizations such as your own entirely
20 outside the carriers and thus escape this self-taxing arrange-
21 ment.

22 Coming to the question would you feel,
23 assuming that we were able to do the other thing that you
24 requested, would you feel that it would be unfair or would it
25 be fair for your Association to be a member of the Medical



MR. WAYNE: Also it might be reasonable that

you might not be limited by the maximum premium, at least
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see the charges that you are making, taken in total, are
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ing to the maximum premium set up. Coming to your complaint
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assuming that we were able to do the other thing that you
requested, would you feel that it would be unfair or would it
be fair for your Association to be a member of the Medical



1 Carriers Incorporated to the extent of being called upon to
2 participate in the pooling arrangements? One point I would like
3 to make there is this: That this could conceivably benefit
4 your Association because carriers do carry more than the average
5 proportion of over 65 and you may well benefit by the pooling
6 arrangement. I would like to come to a certain question on
7 that and that is what your Association does in that respect
8 but first of all, my first question is would you feel it would
9 be fair?

10 MR. OSLER: In answer to the first question
11 sir, it is hard to give it a straight answer at this time.
12 On the face of it the function of Medical Carriers Incorporated
13 seems to be -- to oversimplify it -- to strike an average rate,
14 a rate that is going to apply to all carriers of any type.

15 MR. NAYLOR: I don't believe so. No, I think
16 the maximum premiums are stipulated. Those are just maximum
17 premiums and they are not entirely done by Medical Carriers
18 Incorporated.

19 MR. OSLER: If you like, they are going to
20 suggest certain rates. Our difficulty is that they are working
21 in a quite different framework. They are taking into account
22 costs, generally speaking, of an insured or of the insuring
23 group, taking those costs and that overhead, and so on, into
24 their decision on rates.

25 Now we have perhaps a different type of

their decision on rates.

group, taking those costs and that overhead, and so on, into

costs, generally speaking, of an insured or of the insured

in a quite different framework. They are taking into account

various certain rates. Our difficulty is that they are working

MR. COLLIER: If you like, they are going to

incorporated.

premiums and they are not entirely done by Medical Care

the maximum premiums are stipulated. Those are just maximum

MR. MAYNARD: I don't believe so. No, I think

a rate that is going to apply to all carriers of any type.

seems to be -- to overcomplicate it -- to strike an average rate.

On the face of it the formation of Medical Careers Incorporated

also, it is hard to give it a straight answer at this time.

MR. COLLIER: In answer to the first question

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and that is what your Association does in that respect

arrangement. I would like to come to a certain question on

proportion of over 67 and you may well benefit by the pooling

your Association because carriers do carry more than the average

to make there is this: That this could conceivably benefit



1 overhead. We have one plan that costs us in the neighbourhood
2 of \$1,000,000 servicing a particular group rather than for us
3 servicing 100,000 and I am simply giving an example of the
4 different kinds of costs, different kinds of overhead we have
5 got to be concerned with. If we are obliged to go along with
6 rates as reached by Medical Carriers Incorporated, they may
7 very well not be appropriate to us.

8 MR. NAYLOR: Perhaps to clarify what I was
9 asking there, I intended to say first, to express my own personal
10 opinion, it perhaps would be reasonable and logical that you would
11 not be bound completely by the maximum rates, but I really was
12 not asking about that particular point. I was asking would you
13 consider it would be fair that your organization, your
14 Association should be required to participate in a pooling
15 arrangement to the extent of bearing a fair share of the cost
16 of insuring the high cost risk? As I say this could be to your
17 advantage possibly if you are carrying what might be considered
18 more than the average share of these risks.

19 MR. OSLER: Doctor Ferrier would you like to
20 enlarge on that?

21 DR. FERRIER: We are attempting to answer your
22 question -- for the information of the Committee, I might
23 point out to a certain extent we do, in our program, take
24 responsibility over and above providing service to those who
25 are currently paying premiums. We have three things for your



overhead. We have one plan that costs us in the neighbourhood

serving 100,000 and I am simply giving an example of the

different kinds of costs, different kinds of overhead we have

got to be concerned with. If we are obliged to go along with

rates as reached by Medical Care Insurance Incorporated, they may

very well not be appropriate to us.

MR. WATSON: Perhaps to clarify what I was

saying there, I intended to say first to express my own personal

opinion, it perhaps would be reasonable and logical that you would

not asking about that particular point, I was asking would you

consider it would be fair that your organization, your

Association should be required to participate in a pooling

arrangement to the extent of bearing a fair share of the cost

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MR. CHAIR: Doctor Fortier would you like to

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DR. FORTIER: We are attempting to answer your

question -- for the information of the Committee, I might

point out to a certain extent we do, in our program, take

responsibility over and above providing service to those who

are currently paying premiums. We have three things for your



1 information.

2 First of all: We carry to any age a beneficiary,
3 a widow and I was thinking of the disabled physically or
4 mentally disabled beyond the age of 19 or to any age.

5 MR. NAYLOR: Mentally and physically?

6 DR. FERRIER: Should they not be able to fend
7 for themselves, they may be carried to any age as continual
8 dependents of the subscriber. Secondly, the pensioner who has
9 participated for a certain number of years in the program, on
10 retirement will then be carried premium free until he is
11 deceased and his wife and his dependents will be carried prem-
12 ium free upon retirement.

13 THE CHAIRMAN: You mean just the wife, not all
14 dependents?

15 DR. FERRIER: Dependents, all qualified
16 dependents, should they be disabled or under age still.

17 MISS McARTHUR: How many years?

18 DR. FERRIER: Two instances; those who have
19 participated in the program for fifteen years, fifteen years
20 from the onset of the program will be carried premium free and---

21 MR. NAYLOR: I was going to ask this question.
22 I am glad you have outlined this because it is very interesting.
23 By way of one question along this line, I am not quite clear
24 as to what persons are eligible to buy your service. Is it
25 just those within the employee group?



Just those within the employee group?

as to what persons are eligible to buy your service. Is it

By way of one question along this line, I am not quite clear

I am glad you have outlined this because it is very interesting

MR. WATSON: I was going to ask this question.

from the onset of the program will be carried premium time and

participated in the program for fifteen years, fifteen years

MR. WATSON: Two instances; those who have

dependents, should they be drafted or under age still.

MR. FRISBIE: Dependents, all qualified

dependents?

THE CHAIRMAN: You mean just the wife, not all

from time upon retirement.

deceased and his wife and his dependents will be covered prem-

retirement will then be carried premium free until he is

participated for a certain number of years in the program, on

dependents of the subscriber. Secondly, the person who has

for themselves, they may be carried to any age as continued

MR. FRISBIE: Should they not be able to fend

MR. WATSON: Mentally and physically?



1 DR. FERRIER: Yes. That is the second point.
2 If I may go back to these other points, because I did not give
3 a complete answer. Secondly, those who had joined the plan
4 prior to I think July 1st 1962 do not have to put in fifteen
5 years but since July 1st then they must put in fifteen years
6 of continuous participation in order to have premium free
7 coverage.

8 MR. NAYLOR: Everybody, that is on July 2nd
9 1962.

10 DR. FERRIER: And there is an agreement that
11 our program will take our share of the medically indigent who
12 needs service, to come to us for service.

13 MR. NAYLOR: I would like you to clarify that.
14 I am not very clear as to what you mean by that.

15 DR. FERRIER: For instance, someone who in,
16 first of all, in an emergency who needs care, whether or not
17 -- and can't get the service of another physician at the moment
18 will be provided whether or not they are members; whether or
19 not they are able to pay, mainly, those who no longer are
20 eligible because, for some reason -- but is indigent.

21 MR. NAYLOR: Just to clarify that, you mean
22 this: Any person in the community where you operate doesn't
23 matter whether they have ever been a subscriber or everywhere?

24 DR. FERRIER: In the first instance under an
25 emergency situation obviously not in an elective situation



DR. FRANKLIN: Yes. That is the second point.
If I may go back to these other points, because I did not give
a complete answer. Secondly, those who had joined the plan
prior to I think July last 1962 do not have to put in fifteen
years but since July last when they must put in fifteen years
of continuous participation in order to have premium free
coverage.

MR. NAYLOR: Everybody, that is on July last

DR. FRANKLIN: And there is an agreement that
our program will take our share of the medically indigent who
needs service, to come to us for service.

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matter whether they have ever been a subscriber or everywhere?
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1 where it may be they will get the service of the doctor, but
2 in an emergency.

3 MR. NAYLOR: What is your criterion for that?
4 If they need the treatment and can't pay for it you will look
5 after them? Is that all it boils down to?

6 DR. FERRIER: Yes.

7 MR. NAYLOR: And then the second thing you
8 said was --?

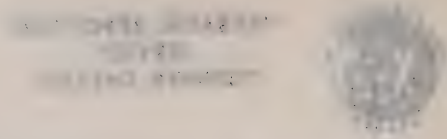
9 DR. FERRIER: The second thing is someone who
10 had perhaps been a subscriber and no longer able to pay the
11 premium, for one reason and another.

12 MR. OSLER: May I pick up your eligibility
13 question sir?

14 MR. NAYLOR: If you are finished, I would like
15 you to carry on with that.

16 MR. OSLER: The initiation of the plan is
17 described in the second part of the brief, that is beyond the
18 blue spacing sheet. It was originally initiated by co-operation
19 -- I don't think we need to go into details at the moment --
20 co-operation between one employer and a very large group of
21 his employees who were provided with a choice between a normal
22 insurance scheme and this scheme. The great majority selected
23 this scheme.

24 Since that time there have been I think two
25 sizeable groups who have come in on the same type of



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DR. FINKELSTEIN: The second thing is someone who

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stakeholder groups who have come in on the same type of



1 arrangement, that is the agreement for partial payment of
2 payments by the employer, the balance by the employee and the
3 group comes in as a whole. In the immediate future the plan
4 is continual enrolment of groups such as that but they need not
5 necessarily in perpetuity be limited to industrial groups. At
6 that time they may find there are other groups want to approach
7 us. Of course they will have to be considered on their merits.

8 MR. NAYLOR: I presume that you serve through
9 groups, employee groups I take it?

10 MR. OSLER: Employees, dependents, all through
11 employers, yes.

12 MR. NAYLOR: I presume the proportion of
13 retired people wouldn't be very much because you have not been
14 going -- did you take on any of them that were on retirement
15 in July when the plan started?

16 MR. BARKER: There were approximately 300
17 available.

18 MR. NAYLOR: You took those up at that time
19 and the proportion of retired people that you have covered
20 would presumably continue to increase as the plan goes on.

21 MR. BARKER: Depending upon whether more pass
22 away than retire or not.

23 MR. NAYLOR: Likely the retired population
24 would probably become a greater proportion of the total.

25 Do you have a uniform charge to all your employees to the groups



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MR. MAYOR: Lately the retired population uniform charge to all your employees to the group



1 or do you do any differentiation or what might be called
2 experience rating between them?

3 MR. OSLER: Uniform charges up to this point.

4 MR. NAYLOR: I think perhaps that is all I
5 have.

6 THE CHAIRMAN: Just one question from the Chair.
7 Is participation in your plan a voluntary basis for the
8 employees of the company that are co-operating in it or is it
9 compulsory for all employees to participate?

10 MR. OSLER: It is voluntary in all cases and
11 I think invariably the choice is made annually in each case
12 so that the employer has two alternative systems: Can either
13 take our system or take the commercial insurer and this
14 election may be made once a year by him or any member of the
15 group that is covered.

16 THE CHAIRMAN: And is there a waiting period
17 before the employee can participate or is it immediately upon
18 employment can they enter the plan?

19 MR. OSLER: Yes.

20 MR. BARKER: I would like to correct one
21 statement here. I think there is a misunderstanding. The
22 employee's choice as to whether he is covered or not, it does
23 differ in some plants. First, there are six groups at the
24 present time now, two in one large plan and two groups in another
25 large plan. In some plans there is a choice yearly as to



1. The first question is whether or not the plan is voluntary.

2. The second question is whether or not the plan is compulsory.

3. Mr. COLLIER: Uniform changes up to this point.

4. Mr. MAYOR: I think perhaps that is all I

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7. employees of the company that are co-operating in it or is it

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21. employee's choice as to whether he is covered or not, it does

22. differ in some plans. First, there are six groups at the

23. present time now, two in one large plan and two groups in another

24. some plans there is a choice yearly as to



1 whether they want to belong to our plan or another. It has
2 been our position from the start there should be a choice.
3 Several employers, or some employers take a dim view of
4 carrying two types of coverage and they take the position if
5 the majority of their employees select one type of coverage,
6 then that is the type of coverage they will provide for the
7 employees. If they want it they can participate in it. If
8 they do not want it, they can purchase what they want elsewhere.
9 It is not the choice of the employer that they belong to the
10 plan.

11 MR. NAYLOR: Would you explain a little more
12 what your premiums are? The brief indicates what you call a
13 sponsorship fee of \$135.00 per family. Is that like sort of
14 the initial enrolment fee? Is there an annual premium or
15 monthly, or weekly premium in addition to that?

16 MR. OSLER: That is correct sir. The sponsor-
17 ship fee was initiated largely to accumulate the necessary
18 capital to get this thing started. Principally to take care
19 of overhead, replacement, continuing expense and that sponsor-
20 ship fee is being continued so that all now joining are still
21 required to pay the same fee as they would have had had they
22 been original sponsors.

23 Then in addition to that, the normal sub-
24 scription collected, I think, monthly in every case by the
25 employer is charged for the service provided.



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scription collected, I think, monthly in every case by the
employer is charged for the service provided.



1 MR. NAYLOR: Would you quote what that is?

2 MR. OSLER: \$4.50 for a single person and
3 \$12.00 for a family.

4 MR. NAYLOR: Monthly?

5 MR. OSLER: Yes.

6 MR. NAYLOR: If any one of these groups that
7 is already in your plan, and when a new employee completes his
8 eligibility and becomes eligible, how does he pay this \$135.00?
9 It mentions by payroll deduction. Is it collected over the
10 first year? How long is it spread out?

11 MR. OSLER: There are different schemes. The
12 spread is to a maximum of five years. Normally deduction is
13 made on the order of \$1.00 a month. This varies with the
14 different employers.

15 MR. NAYLOR: Generally it is spread over a
16 considerable period so it does not become too heavy?

17 MR. OSLER: Yes.

18 THE CHAIRMAN: This would be deducted from
19 pay in addition to the premium of \$12.00 a month for a family?

20 MR. OSLER: That is correct sir.

21 THE CHAIRMAN: If he did not stay with the
22 company, if he left after a year, he would not be obliged to
23 pay the rest of this sponsorship fee? It would just be as long
24 as he is working?

25 MR. OSLER: He is entitled but not obligated.



MR. MAYNARD: Would you quote what that is?

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MR. OSBORN: He is entitled but not obligated.



1 THE CHAIRMAN: This leads to another question:
2 Such an employee leaving, an employee of one of these employers
3 that is in your plan, has he any way of getting continuing
4 coverage when he leaves?

5 MR. OSLER: He is entitled to continue.

6 THE CHAIRMAN: By paying this same premium
7 rate directly to you?

8 MR. OSLER: Yes.

9 THE CHAIRMAN: This would only be true if he
10 stayed in the same locality.

11 MR. OSLER: Geographical area, yes sir.

12 THE CHAIRMAN: Mr. Whitney?

13 MR. WHITNEY: Thank you Mr. Chairman. This is
14 a very interesting development and I think we have to under-
15 stand it very thoroughly to know just how we can develop this
16 recommendation on the medical services insurance plan and have
17 it live with this type of organization. To begin with, Mr.
18 Osler have you formed an opinion yet as to whether you actually
19 do come under this bill with the present organization you have
20 and I am referring, or thinking, not exclusively so, to Section
21 1(b) and also Section 5?

22 MR. OSLER: Well sir in my view we have to go
23 from (b), which defines a carrier as an Association that sells
24 or provides medical services insurance, and then we go over
25 to Subsection (i) medical services insurance means a contract



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MR. WILLIAMS: Thank you Mr. Chairman. This is

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MR. COLLIER: Well sir in my view we have to go from (b), which defines a carrier as an Association that sells or provides medical services insurance, and then we go over



1 or arrangement whereby a resident is covered for medical or
2 surgical care or services, or the cost or a portion thereof,
3 so it would seem to me on the face of it that if you sell a
4 contract which gives a person coverage for medical or surgical
5 care that you are selling insurance within the meaning of this
6 Bill and that is our type of contract, of course.

7 MR. WHITNEY: Do you actually have a form of
8 contract?

9 MR. OSLER: Yes sir.

10 MR. WHITNEY: Relating strictly to the
11 medical services that are to be provided and the dues or
12 premiums to be paid for those services?

13 MR. OSLER: Yes.

14 MR. WHITNEY: You have a separate form of
15 contract which is not contained in other contracts?

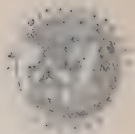
16 MR. OSLER: No. We have a contract and a
17 membership card that is issued to subscribers.

18 MR. WHITNEY: Could we be supplied with a
19 couple of copies of those?

20 MR. OSLER: Yes sir. I am afraid we have not
21 them here today but we can supply you with a copy.

22 MR. WHITNEY: To get to the next thing, legal
23 structure of your organization. What organization owns the
24 building? I am thinking legally now, in legal structure terms.

25 MR. OSLER: The Association as such, which is



901

on arrangement whereby a resident is covered for medical or surgical care or services, or the cost or a portion thereof, so it would seem to me on the face of it that if you sell a contract which gives a person coverage for medical or surgical care that you are selling insurance within the meaning of this Bill and that is our type of contract, of course.

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1 an incorporated, non-profit, non-share body.

2 MR. WHITNEY: Your Company is incorporated
3 under the Companies Act in the Association section?

4 MR. OSLER: That is right.

5 MR. WHITNEY: And the title to the property
6 is held in that Association, is that it?

7 MR. OSLER: I must say it was someone else in
8 my office that handled this, but that is my impression anyway.

9 MR. WHITNEY: And membership in the Association,
10 is it a classified membership or does anyone who comes under
11 these services become a full-fledged voting member?

12 MR. OSLER: No. As with many of this type of
13 organization, the actual members of the Board of Directors who
14 are elected are not too extensive.

15 MR. WHITNEY: Then how under your by-laws do
16 you elect the members who are the voting members of the
17 Association or Corporation who in turn, as you say, are elected
18 as Directors. How do they qualify? How is that done?

19 MR. OSLER: I omitted to bring a copy of the
20 by-laws with me to clarify that.

21 THE CHAIRMAN: Would that be included in your
22 Letters Patent?

23 MR. OSLER: No sir. That is covered by by-law.

24 MR. WHITNEY: Could you tell me?

25 MR. OSLER: Generally speaking, and I cannot be

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1 too accurate on this sir, provision is made for representation
2 in certain proportions from the sponsoring groups. That is, a
3 particular group of employees that comes in as a group has
4 certain members on the Board. The next group has certain
5 members, and so on.

6 In addition, there is a proportion of public
7 members who are not related in any way to the employees,
8 employer or their groups.

9 MR. WHITNEY: Do they come on by invitation?
10 Is that the way you would get your public representation?

11 MR. OSLER: Yes. They are invited by the
12 Board and are elected, and they indicate they will accept, of
13 course.

14 MR. WHITNEY: Do you have a list of the
15 persons who are on the Board at the present time?

16 MR. OSLER: We can certainly make one up for
17 you sir.

18 MR. WHITNEY: Would you mind, and give us the
19 occupation of those people so we can see just what sort of
20 composition you do have.

21 MISS McARTHUR: Is this composition laid down
22 in the Act?

23 MR. WHITNEY: No, it wouldn't be in the Act.

24 MR. OSLER: No. I am speaking from memory,
25 the Letters Patent read as usual X number of people and such

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1 others as may become members. There is nothing particularly
2 in the---

3 MR. WHITNEY: It would not be in the Statutes.
4 You would have provisional Directors for the charter, in the
5 usual way, and this could be people in law offices get out the
6 charter and then you set up the by-laws and have an organization
7 and the legal people retire and in come the proper incumbents
8 who are going to run this Corporation. I am just interested to
9 know what interests are involved in the control of that
10 Corporation.

11 MR. OSLER: I can tell you sir. There is no
12 secret about it. I don't know the proportions but apart from
13 the public members they are all, or almost all in some way
14 connected with the United Steel Workers Union either through
15 the particular Local or the particular group or through one
16 of the Regional offices.

17 MR. WHITNEY: The original money put up, the
18 \$800,000 -- if these questions now are in any way going too
19 far, and you don't wish to answer, it is perfectly all right
20 if you feel there are certain things that are classified
21 information.

22 MR. OSLER: We have had no objection so far.

23 MR. WHITNEY: I am just wondering how you
24 financed the original \$800,000. Who put that up? Was it the
25 Union that put that up?



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1 MR. BARKER: These subscribers through the
2 Health Plan operating back as far as 1959 started contributing
3 toward that amount of \$135.00 and it raised the money to build
4 the Health Centre. We did not, when we started the Health
5 Centre, we did not have sufficient money at the time. We
6 borrowed on the strength of this money being received, and this
7 \$135.00 paid by the subscribers will pay for the erection of the
8 Health Centre.

9 MR. WHITNEY: Have you looked at the standard
10 contracts suggested in Schedule A of the Bill and are your
11 services as extensive or more so than the standard coverage?

12 MR. OSLER: They are more so sir. Dr. Ferrier
13 perhaps could elaborate if you wish to pursue that.

14 DR. FERRIER: Services provided are all
15 services being provided by physicians, including any and all
16 preventive services, any check-up examination. In other
17 words, there is no schedule for extra charges. The services
18 provided by physicians, I think that in the broadest terms --
19 my assumption is that the standard contract might be very
20 general -- expected to provide some 60 to 75% of the total
21 cost of physician services; whereas ours would be, if the
22 services are received in our facility or on referral by a
23 member of our staff, or on the exception, an accident travelling
24 outside the area, then 100% of physician services would be
25 provided, with no exception.



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1 MR. WHITNEY: Paid by your organization for the--

2 DR. FERRIER: In these exceptions, when you
3 are travelling within an area and have an emergency situation
4 or if they receive their service from the staff, then 100% --
5 be no billing, no charge for the physician service.

6 MR. WHITNEY: The medical staff in this clinic,
7 I would expect renders free service. If some of them have to
8 go outside of your clinic for attention in hospitals and so
9 on---

10 DR. FERRIER: Where we do not provide the
11 specialty, and the specialty service is required, we arrange
12 for it and pay for it.

13 THE CHAIRMAN: Would you pardon a question
14 being interjected in here, which is directly in relation to
15 the question you have asked? It is my understanding that you
16 are going to provide us with a copy of your contract.

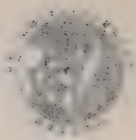
17 DR. FERRIER: That is correct.

18 THE CHAIRMAN: The contract between your
19 Corporation and the individual participating in it. Will
20 that contract define the services that are available to the
21 extent that we can relate the service that you give to the
22 services that are provided under Schedule A?

23 DR. FERRIER: Yes sir.

24 THE CHAIRMAN: Thank you.

25 MR. NAYLOR: If a subscriber is travelling and



MR. WHITNEY: Paid by your organization for the

DR. FERRIER: In these exceptions, when you

or if they receive their service from the staff, then 100% --

be no billing, no charge for the physician service.

MR. WHITNEY: The medical staff in this clinic,

I would expect renders free service. If some of them have to

go outside of your clinic for attention in hospitals and so

DR. FERRIER: Where we do not provide the

specialty, and the specialty service is required, we arrange

for it and pay for it.

THE CHAIRMAN: Would you pardon a question

being interjected in here, which is directly in relation to

the question you have asked? It is my understanding that you

are going to provide us with a copy of your contract.

THE CHAIRMAN: The contract between your

Corporation and the individual participating in it. Will

that contract define the services that are available to the

extent that we can relate the service that you give to the

services that are provided under Schedule A?

DR. FERRIER: Yes sir.

THE CHAIRMAN: Thank you.

MR. NAYLOR: If a subscriber is travelling and



1 requires medical care, do you pay for that outside of your
2 geographic area? I mean pay for the service? The present
3 subscriber needs medical service outside your geographic area.

4 DR. FERRIER: When he is travelling outside and
5 requires service, couldn't obtain it from the centre.

6 MR. NAYLOR: You pay for that? The subscriber
7 has all his medical care provided?

8 DR. FERRIER: Yes.

9 MR. WHITNEY: We could go on with that. When
10 you say outside, how far outside do you go on that?

11 DR. FERRIER: Anywhere in North America. Any-
12 where he happens to be travelling. Understand, this has to
13 be a bona fide emergency situation, not something which he
14 specifically travels to get, but an emergency service based on
15 clinical evidence from the physician rendering the service.

16 MR. WHITNEY: And if he happens to be in
17 Europe when he breaks his leg and needs attention would this
18 be covered?

19 DR. FERRIER: I think not. It is within---

20 MR. WHITNEY: You are within North America?

21 DR. FERRIER: Yes.

22 MR. WHITNEY: Do your subscribers, or the
23 people who join your Association as members, do they only come
24 to you in groups? Is there any individual contract written?

25 DR. FERRIER: Only in groups.



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34 to you in groups? Is there any individual contract written?
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1 MR. WHITNEY: Only in groups?

2 DR. FERRIER: Yes, and as pointed out when a
3 person leaves a group and has already paid the initiation fee,
4 may continue as an individual.

5 MR. WHITNEY: Does he have to be a qualified
6 member of a group under a Union contract? Does he have to be a
7 Union member to resort to this service?

8 DR. FERRIER: It is not the intent of the
9 Association to limit to members of any particular group,
10 Union or otherwise. So far the fact it is limited to members
11 of Union groups in Saulte Ste. Marie is because of the history
12 and the interest shown. There are others who have begun to
13 express interest. We would like-- the direction in the long
14 run is to be a community program, having members of any group
15 in the community that desire it.

16 MR. WHITNEY: At the moment they are all
17 members of the Union that sponsored the project in the beginning?

18 DR. FERRIER: Yes.

19 MR. BARKER: The established policy -- the
20 Committee thought it would be first available to towns that
21 is showing interest at that time. Second, of course, goes to
22 all affiliates of the Labour Council and thirdly to the
23 community as a whole and we are now at the stage of the
24 affiliates to the Labour Council.

25 MR. OSLER: There is nothing to bar a non-



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MR. OSLER: There is nothing to bar a non-



1 affiliated group who are now showing an interest.

2 MR. BARKER: Once the people have had an
3 opportunity to participate and there is space available, then
4 other people will be taken in.

5 THE CHAIRMAN: Would you pardon another
6 interruption here please? In the companies that are participa-
7 ting in this, are the office workers members of their Union?
8 Do they have a Union?

9 MR. BARKER: I might point out that there are
10 two companies that have both production workers and office
11 workers in, and when we go to a company where the employees
12 in the Union are desirous of becoming part of the Health
13 Centre, we tell them we will make it available to any employee
14 of the company.

15 So far the companies have not seen fit to
16 contribute on behalf of the employees excluded from the Union.

17 THE CHAIRMAN: That is the company policy, that
18 the company does not participate for those employees who are
19 not members of the Union?

20 MR. BARKER: Right.

21 THE CHAIRMAN: Therefore, the company not
22 participating the individuals do not have or are not eligible
23 for the participation?

24 MR. BARKER: So far as we are concerned they
25 are. If they are employed by an employer who is participating



Resolved: That the following be invited to participate in the discussion on the subject of the health of the workers in the company.

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THE CHAIRMAN: Therefore, the company not participating the individuals do not have or are not eligible for the participation?

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1 in the Health Centre, we will make it available to these
2 employees.

3 THE CHAIRMAN: But these same employees could
4 participate in another health insurance program, and the
5 companies for which they are working would contribute towards
6 that?

7 MR. BARKER: Some of them. Some yes and some
8 no. I am thinking particularly of the large group, Algoma
9 Steel. They will contribute towards another type of coverage
10 for employees excluded from Union and they will not contribute
11 for those same employees towards the Health Centre.

12 THE CHAIRMAN: In some companies employees who
13 are not a member of the Union participating in this would not
14 be able to participate in an insurance program in which the
15 company would contribute.

16 MR. OSLER: I do not want to elaborate
17 unnecessarily but I think one point perhaps should be made.
18 Under the Labour Legislation and the practice, there is
19 established what is known as a bargaining unit and not all
20 employees within that unit are necessarily members of the union.
21 What we are dealing with is bargaining units as groups with
22 maybe 80% Union membership, maybe 60%, maybe 100% but we are
23 dealing in terms of the bargaining unit. It is not necessarily
24 100% membership, this group that we are entitled to represent.

25 THE CHAIRMAN: Mr. Whitney?



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THE CHAIRMAN: Mr. Whitney?



1 MR. WHITNEY: In these groups which are employee
2 groups, is there any qualification or necessity or is it a
3 condition of employment before an employee can become a member
4 of a group, do you know whether they have to have a medical
5 examination as a condition of employment?

6 MR. BARKER: In our program?

7 MR. WHITNEY: I am not thinking necessarily
8 just of your program. Does it work through the whole thing?
9 When a person, say, applies for a job at Algoma Steel and
10 becomes a member of the Union or is a member of the Union is there
11 a medical examination as a condition of hiring?

12 MR. BARKER: Not so far as our program is
13 concerned. You are speaking now as to whether they belong to
14 a planned program of any kind?

15 MR. WHITNEY: I am trying to find out what
16 type risks you get.

17 MR. OSLER: Do they require an examination
18 before they hire them?

19 MR. BARKER: There is no medical as far as our
20 program is concerned. If they become an employee, they are
21 eligible.

22 MR. OSLER: When they apply for a job at
23 Algoma, is there a medical examination by the company?

24 MR. WHITNEY: Required by the company?

25 MR. BARKER: For employment, yes.



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MR. OSLER: When they apply for a job at

MR. WHITNEY: Required by the company?



1 MR. OSLER: And is this true in all the groups
2 or just some? Do other employers require this?

3 MR. BARKER: Not all employers require a
4 medical, no.

5 MR. NAYLOR: Not all employers in your plan
6 is that what you mean?

7 MR. BARKER: Yes. In no case is a medical
8 required for them to be eligible for our plan.

9 MR. WHITNEY: That is quite obvious. You
10 don't need a medical condition in your plan if there is one
11 in a prior situation as the man comes to you.

12 DR. FERRIER: That is true for the employee.
13 That does not relate to his beneficiary.

14 MR. WHITNEY: No, of course not. I am looking
15 at this community situation in the family risk coverage. I
16 did not get your rate structure. Single \$4.50 a month and
17 what was the other?

18 DR. FERRIER: \$12.50 for family; only two
19 rates.

20 MR. WHITNEY: Is there any selection within
21 the family group? Have you found that three of the family
22 group were chronic cases, does that affect your \$12.50 rate
23 at all? If it happened to be that this employee had two or
24 three people in the family who were continuously under medical
25 treatment because of chronic conditions which seem to be in the



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DR. TERRIER: \$12.50 for family; only two rates.

MR. WHITNEY: Is there any selection within the family group? Have you found that three of the family group were chronic cases, does that affect your \$12.50 rate at all? If it happened to be that this employee had two or three people in the family who were continuously under medical treatment because of chronic conditions which seem to be in the



1 family, would this affect you in accepting the group?

2 DR. FERRIER: It would not affect us. I think
3 it might affect them in selecting a plan which is comprehensive
4 in coverage. I think there is a tendency for our plan to perhaps
5 select adversely this group.

6 MR. NAYLOR: Are there any individual rates?

7 DR. FERRIER: There are no individual rates, no.

8 MR. NAYLOR: You charge everybody---

9 DR. FERRIER: Simply two rates, single and
10 family, dependents, no matter how many.

11 MR. NAYLOR: Is that figure \$12.50? I had
12 noted it as \$72.00 per year.

13 DR. FERRIER: \$4.50 or \$12.50, yes.

14 MR. NAYLOR: You say you have what, six or
15 eight groups probably under your clinic. Now what portion of
16 the premium is paid by the employer at the present time? Is
17 it two-thirds?

18 MR. BARKER: Approximately two-thirds in some
19 cases but three-quarters in another. One recently is a 60/40
20 basis.

21 MR. NAYLOR: So at the present time then the
22 employer is accepting the heavy subsidy in this rate structure?

23 MR. BARKER: That is right.

24 MR. CASWELL: Mr. Chairman, the employer does
25 not pay any part of the initiation fee.



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not pay any part of the initiation fee.



1 MR. BARKER: No.

2 MR. WHITNEY: On that question of initiation
3 fee, is that a redeemable debenture? If the person quits and
4 leaves the area, having only been there two or three months
5 and having paid the \$135.00 does he get any reimbursement?

6 MR. OSLER: No.

7 MR. WHITNEY: It is one---

8 MR. OSLER: Final charge, yes. This is our
9 contribution to stability in the community.

10 MR. NAYLOR: And this fee is the same for a
11 single person as for a family?

12 MR. OSLER: Yes.

13 MR. WHITNEY: As I understand it all the doctors
14 are on salary in this organization?

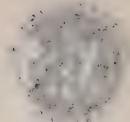
15 MR. FERRIER: Yes. I suppose some definition
16 of salary -- the only definition for salary -- the physician
17 did agree to accept an annual income for that year. It does
18 not vary within the year, if that is what salary means. To
19 the extent of employed by someone other than themselves, this
20 is not the sort of salary.

21 DR. BUTT: Could I have an elaboration on that?
22 What do you mean by that?

23 DR. FERRIER: The answer is no.

24 DR. BUTT: No what?

25 DR. FERRIER: No, they are not on salary.



MR. WHITNEY: On that question of initiation fee, is that a redeemable debenture? If the person drifts and leaves the area, having only been there two or three months and having paid the \$135.00 does he get any reimbursement?

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1 DR. BUTT: They are not on salary.

2 DR. FERRIER: I suppose that means I must
3 explain what they are on.

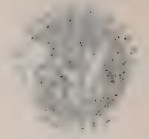
4 DR. BUTT: Yes.

5 DR. FERRIER: The Association, of course,
6 receives all the premium income and then enters into an agree-
7 ment with the medical group as an independent entity to give
8 to them a sufficient amount of money to attract and hold
9 physicians and then the job of the Medical Executive Committee
10 of the staff is to decide how -- what the increment in income
11 will be, what the initial basis of pay shall be and the medical
12 group has the initial income for physicians based on training
13 and experience only and everyone agrees equally to accept an
14 amount of annual income based on their training and experience.
15 Each year the Executive Committee must evaluate whether they
16 will -- there shall be an increment of such and such an amount
17 within the budget they have or whether additional physicians
18 should be -- any specialty should be added. To that extent the
19 physicians could say unanimously we are not on salary but have
20 agreed to accept a fixed income for a period of time to provide
21 full-time service. We are not employed by anyone.

22 MR. NAYLOR: But the cost of providing the
23 service then does not vary directly with utilization?

24 DR. FERRIER: No.

25 MR. NAYLOR: It is more or less a fixed, whole



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1 amount.

2 DR. FERRIER: By the size of the group and the

3 amount---

4 MR. WHITNEY: You cut the melon each year?

5 DR. FERRIER: Yes.

6 MR. CASWELL: And the service is only given
7 within the clinic, by members of the clinic?

8 DR. FERRIER: Yes.

9 MR. CASWELL: They do not go into private
10 practice?

11 DR. FERRIER: No. Full time they provide
12 service.

13 MR. OSLER: May I refer to one question?

14 On the sacrifice of the initiation fee, or whatever we call it,
15 normally this is spread over a considerable period of time in
16 pretty small instalments so that it would not usually happen
17 that a man has sunk a great deal in the organization and then
18 leaves the area.

19 MR. GALLOWAY: While you are thinking of a
20 question, may I ask one which is related to the medical fee
21 situation? Under the Workmen's Compensation Act the workman
22 has the right of choice of a physician or surgeon and it is
23 undoubtedly true that those who are insured by your group may
24 well elect to be treated by your group, in which case you will
25 be rendering an account to the Workmen's Compensation Board.



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1 Do these fees revert to the Association or to this melon you
2 cut up every year?

3 DR. FERRIER: The amount of money that the
4 doctors may provide, so to speak, in a pooled income from
5 whatever the source, no individual doctor would get payment
6 for providing workmen's compensation service to a subscriber.

7 DR. GALLOWAY: Does the medical group collect
8 the Workmen's Compensation or does this money revert back to
9 the Association and become this total income along with
10 premiums and you get a portion of the Workmen's Compensation,
11 plus a portion of the premium?

12 DR. FERRIER: In fact, the medical Board has
13 said in effect that the Administrator of the program will bill
14 only half of the group. The Workmen's Compensation say -- in
15 fact I think he says the income would come to the medical group,
16 not to the Association.

17 DR. GALLOWAY: If you establish an annual
18 amount, then this is an amount over and above and you would
19 divide this at the end of the year?

20 DR. FERRIER: Conceivably it would either mean
21 -- depending on what the budgetary situation was, this may not
22 mean that the Association would have -- necessary for the
23 Association to contribute some amount less because of the
24 additional income from other sources.

25 DR. GALLOWAY: This is really the point I



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DR. GALLOWAY: This is really the point I



1 was trying to get at, whether this money would be used to
2 lower premiums or to increase the doctor's income.

3 DR. FERRIER: It might conceivably -- it is
4 so early in the game, there is so little of this so far, I
5 don't think we have the final answer. I would assume that this
6 might prevent premiums from being increased.

7 MR. CASWELL: May I ask: Does the Association
8 have no control over the decision of this extra money coming
9 from the Workmen's Compensation, whether the doctors put it
10 in their pocket or it goes into the Association's fund? They
11 are paying the doctors, it would seem to me they would be the
12 people to make the decision.

13 DR. FERRIER: They are not paying the doctors.

14 MR. CASWELL: All right, I will withdraw that,
15 they are not paying the doctors. They are telling the doctors
16 there will be so much money available at the end of the year
17 for you to divide, but the doctors who are giving the service
18 to the Workmen's Compensation Board patients; the Workmen's
19 Compensation Board are going to pay for it. Are the doctors
20 the ones who decide where this money goes or the Association?

21 DR. FERRIER: It would be a mutual decision
22 each year, the medical group and the Association. You must
23 look at the budget and find out reasonably what amount of
24 money -- whether there needs to be an increase in the amount
25 of monies provided to medical service to pay the physician's

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there will be so much money available at the end of the year.

For more information, call 1-800-368-2772.

1960-1961

Compensation Board are going to pay for it. Are the doctors

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DR. FERRIER: It would be a mutual decision

each year, the medical group and the Association. You must

Look at the budget and find out reasonably what amount of

1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

Journal of Management Studies, 19(6), 701-718.



1 service or whether, in fact, it would be better for the
2 organization for certain additional facilities to be provided.
3 The whole decision would have to be based on a reasonable
4 premium structure. It would have to be adequate to attract
5 and hold high-quality physicians; have to be -- the decision
6 would have to be made anyway based on all of these considera-
7 tions.

8 MR. CASWELL: In effect, part of the total
9 budget of the Association?

10 DR. FERRIER: Right.

11 DR. BUTT: Who endorses the cheque you get from
12 the Compensation Board? Where is it banked? What do you do
13 with it?

14 DR. FERRIER: I wonder if it is finally
15 decided. At first there were a couple of cheques that came
16 into a specific physician. The physician endorsed these and
17 they were deposited in, I believe, the medical account.

18 DR. BUTT: To the medical account?

19 DR. FERRIER: And in to the Association, which
20 later on I think was assigned the group compensation number and
21 again this would be endorsed I think to the medical account.

22 DR. BUTT: To the medical group only?

23 DR. FERRIER: To the medical group account.

24 DR. BUTT: In other words, it cannot be used
25 for expanding the Association any way?



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the whole thing would be a responsibility

organization for which the Association would be responsible

service or whether, in fact, it would be better for the



1 DR. FERRIER: It can, in that it would reduce
2 the need for any increase in the amount budgeted -- the amount
3 which was allocated at the end of each year to the physician
4 services -- be more in the Association's budget.

5 DR. BUTT: I am interested in this specific
6 thing, that you take a cheque and where does it go? As you
7 said it went first to the physician and now you have changed
8 it and it now goes to---

9 DR. FERRIER: The medical group account. In
10 one instance I am aware of, the only instance, it went into
11 the medical group account.

12 DR. BUTT: Not into the Association?

13 DR. FERRIER: Not into the Association.

14 THE CHAIRMAN: I think we can get at this
15 in another way. I presume that payment from the Workmen's
16 Compensation Board would be paid from a billing, from an
17 invoice?

18 DR. FERRIER: Yes.

19 THE CHAIRMAN: Who issued the invoice?

20 DR. FERRIER: Issued by the Administrator of
21 the Association.

22 THE CHAIRMAN: There must be an invoice going
23 out?

24 DR. FERRIER: Yes.

25 THE CHAIRMAN: And this invoice would be in



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DR. FERRIER: Issued by the Administrator of

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DR. FERRIER: Yes.

THE CHAIRMAN: And this invoice would be in



1 the name of the group or the physician? Would it be in the
2 name of the Association or some doctor?

3 DR. FERRIER: No, I think in the name of the
4 medical group or the name of the physician in this instance;
5 not in the name of the Association.

6 MR. WHITNEY: What is the name of the medical
7 group? What do you call it?

8 DR. FERRIER: It's the -- there are three names:
9 The Group Health Association, which is the Board of Directors.
10 There is the medical staff of the Group Health Centre, which
11 is the name of the medical group, the medical staff of the
12 Group Health Centre.

13 DR. BUTT: And they would receive the cheques,
14 the medical staff of the Group Health Association? The cheque
15 would be deposited to them, is this correct?

16 DR. FERRIER: Yes.

17 DR. BUTT: This is where it would go in most
18 instances.

19 THE CHAIRMAN: Does your Letters Patent or
20 did your Letters Patent authorize you, the Association, to
21 charge fees for medical service?

22 DR. FERRIER: No. I think that is the reason
23 -- the Association cannot charge fees for medical service. Only
24 the physician can.

25 MR. OSLER: Roughly speaking the power is to



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1 arrange for the provision of medical service. That is almost
2 verbatim.

3 MR. CASWELL: I don't think we are concerned
4 with who gives this money, except that it appears that the
5 medical group are getting a sum from the Association to operate
6 the clinic with, and then, in addition, they are charging for
7 private work, and this money comes from the Workmen's Compen-
8 sation Board. This is actually what it amounts to.

9 DR. FERRIER: The compensation service, first
10 of all, can only be provided to subscribers. However, these
11 services are being paid for by an outside---

12
13
14
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verbatim.

MR. GARDNER: I don't think we are concerned

with who gives this money, except that it appears that the

medical group and the hospital association is operating

the clinic with, and then, in addition, they are charging for

services, and this money goes into the hospital's general

action board. This is actually what it amounts to.

MR. GARDNER: The committee has decided, I think

of all, can only be provided to subscribers. However, these

services are being paid for by an outside---



1 MR. WHITNEY: I do not think you have answered
2 the Chairman's question. What is the heading on the invoice?
3 What are the words? Or what is the group called?

4 DR. FERRIER: I haven't seen such an invoice.
5 I think now we have been assigned a group
6 Compensation number, and, therefore, we bill in that name.

7 THE CHAIRMAN: Mr. Whitney and ladies and
8 gentlemen of the Enquiry, this is all helpful information. I
9 am beginning to wonder whether we are straying into a field
10 here that is really relevant to what we are required to do. I
11 think if we pursue this line further, I would like the individual
12 to just state how it is relevant.

13 MR. SIMON: I was beginning to wonder.

14 MR. WHITNEY: Mr. Chairman, I would think that
15 all these questions are really relevant to give us a clear
16 picture of the organization and how it works, because we are
17 going to have to live with it in designing this plan and while
18 some of the questions in themselves, the single questions might
19 seem to be a little off the track, I think it helps us to get
20 a clear picture of how the whole thing works. Some question
21 may seem unimportant, but taking it along with others, I feel
22 that you have to have this picture in order to treat properly
23 the people before us and I haven't myself been concerned about
24 irrelevancy. I do not know what Mr. Osler has felt. If we are
25 going too far, we do not wish to. We are trying to get the full

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1 information.

2 THE CHAIRMAN: They are incorporated and it is
3 not our prerogative to police an Incorporation.

4 MR. OSLER: There is only this, from our point
5 of view. It is no secret to anybody here that we are on one
6 side of a controversy about how medicine should be practiced.
7 Some people do not agree with any theory of group medicine and
8 others do. To the extent that we are getting into questions
9 bearing only on that controversy, I do not think this may be
10 the place; but to the extent that they are relevant to the
11 main Enquiry, certainly we are prepared to...

12 THE CHAIRMAN: But you are not presenting this
13 with a view to evangelizing the rest of the country that this
14 should be the way it should be operated? You are looking
15 forward to practicing this way in your own community?

16 MR. OSLER: That is correct.

17 MISS McARTHUR: I wonder if I heard correctly.
18 Did I hear that there were, on occasions, arrangements for
19 sub-services and, if so, what did they mean? Or, did I not
20 hear correctly?

21 DR. FERRIER: Yes -- other services of
22 physicians. Because of our size, we cannot have every
23 specialty covered at the Health Centre in Saulte Ste. Marie,
24 and, therefore, for the sub-specialty services, we must
25 arrange for consultation and therapy outside the Centre on



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1 referral.

2 THE CHAIRMAN: Always physicians you are
3 talking about?

4 DR. FERRIER: Yes.

5 THE CHAIRMAN: Mr. Whitney, I did not want to
6 cut you off here. I was just wondering whether we were going
7 a little too far.

8 MR. WHITNEY: Just a comment, in case anyone
9 feels there is any innuendo against the staff doctors in the
10 question that he has asked. The O.M.A. has had a very good
11 look at this situation and the doctors involved and it is
12 considered approved. I mean, no one should here get the
13 feeling that there is something wrong here or improper. There
14 certainly isn't anything and the O.M.A. is quite qualified to
15 police the doctors and there is quite a staff of doctors here.
16 So I think I should make that comment.

17 Just one more question: Do the doctors practice
18 outside of the clinic on a fee basis in the community?

19 DR. FERRIER: No.

20 DR. WHITNEY: They restrict their practice?

21 DR. FERRIER: Yes.

22 DR. WHITNEY: I have no further questions.

23 THE CHAIRMAN: Dr. Galloway?

24 DR. GALLOWAY: Practically all of mine have
25 been answered. I was wondering about one or two small points.



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1 Do you use the services of an optometrist or an ophthalmologist?

2 DR. FERRIER: Both. We provide the refractions
3 and the corrections are provided by the optometrist. We also
4 have ophthalmological consultation -- arrange for ophthalmo-
5 logical consultation.

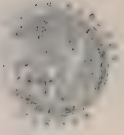
6 DR. GALLOWAY: You said that these were
7 physicians services only that you insure. Do you use other
8 ancillary services, such as optometrists?

9 DR. FERRIER: Nursing, physio-therapy,
10 optometry; so that in addition to physician's services at
11 the Centre we do provide these additional.

12 DR. GALLOWAY: I think my questions have been
13 answered.

14 MR. NAYLOR: This will be a question for you,
15 Dr. Ferrier I think. Is the medical staff of your Association
16 such that you are able to provide medical service quite freely
17 whenever called upon by any of the subscribers? Do you make
18 home calls freely, and so on? Is there anything which sort of
19 limits calling on your services when it might not be quite
20 necessary; or do you think there is any over-utilization or
21 abuse of your services?

22 DR. FERRIER: No. I think one of the
23 attractive things, with doctors who are interested in this
24 kind of service, is that there may be no limitation of frequency
25 of visits to the home, the hospital or in the Centre. I think



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1 the instances in which some people might be quoted as abusive
2 are very rare and I think, in general, our feeling is that,
3 first of all, it is a small number of people and, secondly,
4 if they have something wrong with them we should not use the
5 term "abuse". They have come to the doctor for some reason --
6 it may not be organic.

7 MR. NAYLOR: A subscriber can call one of your
8 doctors at any hour of the night?

9 DR. FERRIER: Yes, and they do.

10 MR. NAYLOR: And ask them to come over?

11 DR. FERRIER: Yes, they do.

12 MR. MAJOR: What do you do if someone in your
13 opinion is guilty of abuse?

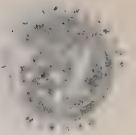
14 DR. FERRIER: The medical staff has discussed
15 this frequently and hope to, by education, provide the service
16 and then try to point out, as patiently as possible, how this
17 is not a wise use of their Health Centre program and attempt
18 to educate them not to use it unwisely.

19 MR. MAJOR: Is there a clause in your agreement
20 that says this agreement is non-cancellable?

21 DR. FERRIER: I think there is no clause but
22 it is, in fact, non-cancellable.

23 MR. MAJOR: It is non-cancellable on a
24 discretionary basis?

25 DR. FERRIER: Yes.



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1 MR. MAJOR: But you can, legally, if you wish
2 to cancel it?

3 DR. FERRIER: Mr. Osler can answer that,
4 whether it is legal or not. I do not think so.

5 MR. MAJOR: If there is no clause in it that
6 you can...

7 MR. OSLER: I think the contract is silent about
8 that.

9 MR. MAJOR: So it is cancellable if you so
10 desire?

11 MR. OSLER: The intent is that it shall not
12 be; but I do not think I can point to a clause that says that
13 it is not.

14 MR. COULTER: Are drugs supplied in your
15 contract?

16 MR. OSLER: No.

17 MR. WHITNEY: Do you in fact supply drugs?

18 MR. OSLER: We have a resident pharmacist on
19 a contract basis and he sells the drugs in our premises.

20 MR. COULTER: The use of the sub-services,
21 are they referrals from the doctors in your organization?

22 MR. OSLER: Yes.

23 MR. COULTER: Either an optometrist or
24 chiropractor?

25 DR. FERRIER: Physiotherapists and optometrists



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1 are referrals from doctors.

2 MR. COULTER: Thank you. That is all I have.

3 MRS. AYLEN: I want to come back to this
4 pharmacy. Is this a concession? Does somebody in the community
5 have a concession to sell drugs in there?

6 DR. FERRIER: No. It is operated by a
7 pharmacist who is independent, who pays the rent for this
8 place.

9 MRS. AYLEN: Do you sell much below the going
10 rate?

11 DR. FERRIER: No. That is up to him. But, in
12 fact, there is some little reduction in the rate.

13 MRS. AYLEN: Do your subscribers ask for drug
14 coverage in their contract? Do they make any application to
15 have that included?

16 DR. FERRIER: In general, it is assumed that
17 with experience and perhaps with increased premium, this could
18 proceed into a fully comprehensive program.

19 THE CHAIRMAN: You state in the brief that this
20 is a contemplated condition later on?

21 DR. FERRIER: Yes.

22 MR. CASWELL: You plan to expand the whole
23 services?

24 DR. FERRIER: I think it is the hope of the
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1 increasing it.

2 MRS. AYLEN: Are the doctors on your staff --
3 do they have ~~privileges~~ in the hospitals?

4 DR. FERRIER: Yes.

5 MRS. AYLEN: All hospitals?

6 DR. FERRIER: Yes.

7 DR. HAMILTON: Thank you, Mr. Chairman. I
8 would like to ask Dr. Ferrier if he has any idea of what the
9 cost of the drugs sold in the Health Centre is in relationship
10 to patient treated? In other words, I am trying to get some
11 idea of what the additional cost...

12 DR. FERRIER: What the cost would be?

13 DR. HAMILTON: Yes.

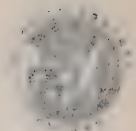
14 DR. FERRIER: I do not think we have had
15 enough experience to know what additional premium would be
16 necessary, if that is your question, to cover drugs.

17 THE CHAIRMAN: Following up Dr. Hamilton's
18 question, there is no compulsion on the part of those
19 participating in the plan to buy their drugs from that drug-
20 store?

21 DR. FERRIER: No.

22 THE CHAIRMAN: So convenience could be another
23 factor. I do not think we could arrive at any figures that would
24 be very helpful.

25 DR. HAMILTON: Except that the vast majority



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1 of the patients would go to the druggist directly.

2 THE CHAIRMAN: If there was a price differen-
3 tial; but convenience may not be a factor or is convenience
4 a factor?

5 DR. FERRIER: I think the factor is there, that
6 it is convenient. Even with no preferential at all, there
7 would be a tendency to use this. However, there is no obliga-
8 tion.

9 MR. OSLER: I think the situation would be
10 like the fellow in the Medical Arts Building. The convenience
11 gives him a great deal of trade.

12 MR. MAJOR: There is no price differential?

13 THE CHAIRMAN: He said there is some.

14 MR. NAYLOR: On page 6, Exhibit 1, the second
15 sentence: "Health Centre benefits generally embrace all
16 necessary medical care at the Centre, in hospital and at home..."
17 Would you please tell me what home benefits are available to
18 the subscriber?

19 DR. FERRIER: The physician visits to the home
20 any time.

21 MR. NAYLOR: At the moment?

22 DR. FERRIER: Yes, at the moment.

23 MR. NAYLOR: But you say that physical medicine,
24 in terms of the services of the physical therapist, are available
25 in the Health Centre?



of the patients would go to the druggist directly.

THE CHAIRMAN: Is there was a price difference?

trial; but convenience may not be a factor or its convenience

a factor?

DR. FERRIER: I think the factor is there, that

it is convenient. Even with no preferential at all, there

would be a tendency to use this. However, there is no oblig-

tion.

MR. OSLER: I think the situation would be

like the fellow in the Medical Arts Building. The convenience

gives him a great deal of trade.

MR. MAJOR: There is no price differential?

THE CHAIRMAN: He said there is some.

MR. NAYLOR: On page 6, Exhibit 1, the second

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1 DR. FERRIER: Yes. In some cases we have
2 arranged for the physio-therapist to provide physio-therapy
3 in the home, in addition to the physician's services. I can
4 think of no others.

5 MISS CARPENTER: You mentioned nursing services
6 included -- what nursing service is included?

7 DR. FERRIER: Nursing service in the centre
8 only. So far, we have used the Health Department Nursing for
9 home service.

10 MISS CARPENTER: This is included in their
11 prescription?

12 DR. FERRIER: No; the arrangement is independ-
13 ent.

14 MISS CARPENTER: They pay independently?

15 DR. FERRIER: Yes.

16 MISS CARPENTER: You mention on page 6
17 periodic health examinations. Is there a controlled use?

18 DR. FERRIER: No -- when desired.

19 MISS CARPENTER: Do the children get those
20 examinations at school then?

21 DR. FERRIER: Some have been. Actually, the
22 pattern of using the Health Centre, that is the Public Health
23 Centre, for well-baby care, will continue and more and more are
24 coming to this well-baby care.

25 MISS CARPENTER: How often do you give the



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MISS CARPENTER: How often do you give the



1 well-baby care -- any time they wish it?

2 DR. FERRIER: Yes.

3 MR. MAJOR: I have a couple of questions.

4 THE CHAIRMAN: Miss McArthur has asked for the
5 floor.

6 MISS McARTHUR: I think Miss Carpenter almost
7 did it. I asked about the sub-services and we were not talking
8 about the same thing. I think you were talking about extra
9 services outside of your plan that was needed that you couldn't
10 buy?

11 DR. FERRIER: Yes.

12 MISS McARTHUR: You do utilize more than
13 physicians within your program and if you have any limitations,
14 I gathered nursing was one of the ones that came to my mind.
15 Nursing, you say now, is only in the clinic?

16 DR. FERRIER: Yes.

17 MISS McARTHUR: Not outside?

18 DR. FERRIER: Yes.

19 MISS McARTHUR: And does that apply to all
20 groups that are related to your program?

21 DR. FERRIER: Yes.

22 MISS McARTHUR: Because you have talked about
23 optometrists, physiotherapists -- those are two things that
24 come to my mind that you have mentioned.

25 DR. FERRIER: Yes.



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1 MISS McARTHUR: That you might use as referrals
2 outside of the clinic, or is everything related to what is in
3 the clinic?

4 DR. FERRIER: Outside the clinic--- I think,
5 for clarification, we are talking about referrals to
6 physicians outside the clinic of sub-specialties, but we do
7 provide other than physician's services at the Centre:
8 Optometry, physical medicine, nursing services in the Centre.
9 Physio-therapy, on occasions, in the home. But, to date, no
10 public health nursing services outside -- in the home.

11 MISS McARTHUR: Would you say the highest
12 proportion of services are related to what goes on in the
13 clinic?

14 DR. FERRIER: Yes.

15 THE CHAIRMAN: In the case of an optometrist
16 providing an examination, how is he paid? Does he submit his
17 bill to the Association, or is he a staff man of the
18 Association?

19 DR. FERRIER: Yes. He is employed by the
20 Association to provide refraction only on the request of a
21 physician.

22 MISS McARTHUR: And are all referrals for this
23 variety of service on the prescription of the physician that
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25 DR. FERRIER: Yes.



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1 MR. WHITNEY: Do you supply eye glasses in
2 the coverage?

3 DR. FERRIER: No.

4 DR. GALLOWAY: The specialists that you have
5 are certified in surgery. Are they in any of the sub-special-
6 ties?

7 DR. FERRIER: In surgery?

8 DR. GALLOWAY: Yes. You have two surgeons?

9 DR. FERRIER: No.

10 DR. GALLOWAY: Are they certified in some
11 specialty?

12 DR. FERRIER: In general surgery, both. But
13 we have two and one is more interested in some fields and the
14 other -- they sort of compliment each other. But they have
15 no additional certification in any of the sub-specialties,
16 except the obstetrician and gynaecologist.

17 DR. GALLOWAY: Who then pays your referred
18 doctors -- the medical plan, or does that come out of the
19 Association fund?

20 DR. FERRIER: That would be considered part
21 of the amount of money which the Association will set aside in
22 the budget for payment for medical services.

23 DR. GALLOWAY: Well then, really it is you,
24 as a medical group, that are paying other medical doctors.
25 Do you pay them your full rates?



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1 DR. FERRIER: Yes; the O.M.A. schedule.

2 DR. BUTT: Are all your specialists certified?

3 DR. FERRIER: No.

4 DR. GALLOWAY: Thank you. What about
5 psychiatrists?

6 DR. FERRIER: We use the services of the
7 psychiatrist in town.

8 DR. BUTT: What proportion do you think this
9 would be of your total outlay?

10 DR. FERRIER: A significant proportion.

11 DR. BUTT: Quite significant?

12 DR. FERRIER: Yes.

13 DR. BUTT: Some are specialists, certified,
14 and some are not. What about a case, shall I say, over and
15 above and beyond the qualifications of the men that are there,
16 what do you do with this case?

17 DR. FERRIER: We refer them out.

18 DR. BUTT: Where to?

19 DR. FERRIER: Either to local physicians who
20 have specialist's certificates or qualifications to do this,
21 or outside to Toronto or London.

22 DR. BUTT: Do you pay for them when they go to
23 Toronto or London?

24 DR. FERRIER: The transportation, no; but the
25 physician's...



DR. FERNBERG: No.

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3 DR. BUTT: Do they have their choice of who
4 they want to go to in Toronto or London?

5 DR. FERRIER: As much, say, as in any other
6 service.

7 DR. BUTT: The individual can say where he
8 wishes to go and who he wishes to see in this case?

9 DR. FERRIER: I think it is exactly as it
10 would be provided for in sole practice in Sault Ste. Marie.
11 By and large, they do not know of anyone anywhere and they
12 take the advice of the physician.

13 DR. BUTT: What happens if this million dollar
14 organization is sold? Where does the money go?

15 DR. FERRIER: It would go to the local
16 hospital, as a matter of fact.

17 MR. OSLER: There is a provision in the
18 Letters Patent for payment of all obligations and anything
19 left over is divided, I think, in our discretion among the
20 local hospitals.

21 MR. CASWELL: There is a sincere hope that
22 it is not going to happen.

23 MR. OSLER: Yes.

24 MR. MAJOR: I would like to clarify a statement
25 Possibly I missed a point. It was made prior in respect to

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1 whether or not your physicians' services program was more or
2 less than the program set forth under Schedule A. Am I right
3 in saying that you felt that your program was better -- and I
4 didn't get why it was better?

5 THE CHAIRMAN: They are going to submit to us
6 a copy of their contract which, according to their statement,
7 has sufficient information for us to relate it to Schedule A.

8 MR. MAJOR: I will accept that.

9 DR. FERRIER: I would hope that the use of the
10 word "better" would be familiar. There is no invidious
11 comparison with any other physicians in that sense of "better".
12 I said that we would say that the plan is more comprehensive
13 and that it covers a greater proportion of the amount -- one
14 hundred per cent of payment for physician's services.

15 MR. MAJOR: You are talking about dollars?

16 DR. FERRIER: Yes; no reference is made to the
17 quality.

18 MR. MAJOR: No. But no reference was made, I
19 gather, to the fact that this Bill covers all the services that
20 could be rendered by a licenced medical practitioner. How can
21 you make it more...

22 THE CHAIRMAN: There are exceptions.

23 MR. OSLER: To put it as conservatively as we
24 can, our exceptions are less numerous than those set out.

25 THE CHAIRMAN: Those exceptions will be set



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1 forth in your contract?

2 MR. OSLER: That is correct.

3 MR. MAJOR: Coming down to page 2, you talk
4 about the best features of group practice. Can you inform
5 us as to what you think are the three or four best features of
6 a group practice in relation to the practice of medicine?

7 MR. OSLER: Before asking Dr. Ferrier or anyone
8 else to answer that, I am just wondering whether this Enquiry
9 wants to get into that, or if it is actually related to the
10 purpose of this Bill.

11 THE CHAIRMAN: Would you state your question
12 again and the page reference.

13 MR. MAJOR: On page 2 it is set forth that
14 this set-up is a unique set-up and that it has such features
15 including the following: "It combines the best features of
16 group practice of medicine with the principle of budgeting in
17 advance for the patient." We have all kind of clinics in the
18 Province of Ontario of one kind or another. We have many
19 group practices in the Province of Ontario, in partnerships,
20 and so on. I want to know what are the best features of this
21 organization in respect of other organizations, in respect of
22 the practice of medicine?

23 THE CHAIRMAN: It is not related to other
24 organizations. It is related to their opinion of the best
25 features of group practice, according to the submission here,



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1 and that is their opinion and not relative to others.

2 MR. MAJOR: Thank you.

3 MR. OSLER: Dr. Ferrier is sold on this and
4 he will take off on it and talk for as long as you like; but
5 I do not know if this would benefit you.

6 MR. MAJOR: Let us get on to page 4, the
7 fourth line down: "...it is a principle completely inconsistent
8 with the promise, implicit in our contract, that service will
9 be made available to all subscribers." This implies to me
10 -- and, Mr. Chairman, I would like to explain my position .
11 I think that the implication in Bill 163 is that the person
12 who buys this contract, that eventually will come out of Bill
13 163, it will be implied that there is a free choice of
14 physician. The statement on page 4 would imply to me that
15 there is not a free choice of physician and that this is a
16 sort of captive audience.

17 MR. OSLER: No. I do not think perhaps that
18 is the correct interpretation. The distinction we are trying
19 to make is that the principle embodied in Bill 163 is that a
20 person will be reimbursed for his medical expenses in a certain
21 way. It is up to him to find where the medical services are
22 available and to get them from somewhere and the Bill is not
23 concerned with where he gets them. Our procedure is that we
24 negotiate with a group of subscribers to provide this service;
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1 than we feel we can efficiently serve.

2 In other words Bill 163 appears to provide that
3 any carrier -- and we are a carrier, as presently defined --
4 must accept all comers if they pay the premium. Our principle
5 is that we have a plan sufficient to take care of the needs
6 of 20,000 people and we do not propose to make contracts that
7 would make it impossible for us to give each of those persons
8 sufficient service. That is the difference.

9 MR. MAJOR: Let us turn it around. A sub-
10 scribe to your Association, he decides to choose a physician
11 who is not a member of your Association, in the ordinary sense
12 of the word. Would your Association cover his bill?

13 MR. OSLER: Not unless it was a referral.

14 MR. MAJOR: This is the type of freedom of
15 choice of physician that I am talking about. So that actually,
16 to have his subscription work to his advantage, he does not
17 have free choice of physician? He has to come to this
18 Association clinic?

19 MR. OSLER: He has the choice of signing up
20 for insurance of some kind and going wherever he likes or
21 making an agreement with us that we will provide service through
22 our physicians.

23 DR. FERRIER: And he will have an early
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1 MR. MAJOR: In your summary of recommendations,
2 item 4, this is a matter of bookkeeping, isn't it, with
3 respect to the working capital and I gather that your book-
4 keeping or accounting system is quite capable of keeping costs
5 of medical care, as against the cost of operation, adminis-
6 tration, and so on. It would be quite possible to set up your
7 books so that your capital account would become a rental
8 proposition. Is there any need for this particular thing to
9 be a deterrent...

10 MR. WHITNEY: What page are we on here?

11 MR. OSLER: I think he is referring to the
12 summary.

13 DR. FERRIER: Item 4 -- reference is made
14 there. We state that we hope that we can avoid the provision
15 which says the maximum subscription may only be X dollars,
16 but the way we have chosen, and we prefer to operate, is to
17 divide our revenue between the regular periodic subscription
18 that carries the cost of actually rendering the service and
19 what we have called a sponsorship fee, which is an initiation
20 fee, if you like. We have a once-and-for-all payment. Our
21 subscribers have preferred this system.

22 MR. MAJOR: This is a private arrangement as
23 far as your subscribers are concerned. What the Government is
24 trying to do here is to find a level whereby it can be assured
25 that the citizens in this Province have a choice. I would say



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2 of physician's services in this Province. Don't you think
3 that all of these people have a working capital and a capital
4 cost involved in setting the rates of subscriptions?

5 MR. OSLER: Certainly.

6 MR. MAJOR: It is not an impossibility that
7 you could set subscription rates for a standard plan that
8 would eliminate the method which you have devised, which is
9 the method you want? This can be done?

10 MR. OSLER: Yes.

11 MR. MAJOR: This is partly an accounting
12 procedure.

13 MR. OSLER: Yes.

14 MR. MAJOR: So this is not necessarily a large
15 deterrent.

16 I think Mr. Naylor has hit the nail on the
17 head, as it were, and pointed out to you that there must be
18 some type of statistical averaging across the Province so
19 that all carriers, be they non-profit or co-operatives, would
20 be expected to carry a reasonable load of this type of coverage.
21 I wouldn't imagine your statement on page 5 -- "...accepting
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1 application would come from your area. I do not think that
2 eliminating your organization and saying, as you set forth
3 in item 6, whereby another arrangement be made, would not
4 necessarily answer the problem because you may not be able to
5 make this other arrangement.

6 Now, if you couldn't make another arrangement
7 whereby you would have another system, you would feel that
8 this Act, as it now stands, would go so far as to give you
9 very dire trouble in co-ordination and making an arrangement
10 of co-ordination under this Act, accounting-wise, etcetera?

11 MR. OSLER: It is a very large subject, sir,
12 and I think we all appreciate -- I think our answer must be
13 yes, that we would anticipate a great deal of difficulty. It
14 seems to me there are two completely sorts of animal: One is
15 an insurer. Whether a private profit-making company or not,
16 they are in the business of providing insurance and reimburse-
17 ment for expenses. The other, our type of organization, is
18 in the business of providing service directly and it seems to
19 me that while our areas of interest and concern overlap, to
20 some extent, there are very wide areas that are going to
21 concern the insurance people that won't concern us, and vice-
22 versa. And the problem of applying a common denominator in
23 a blanket organization that includes both types is going to
24 be difficult, I think.

25 MR. MAJOR: There is somewhere between 40 and

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whereby you would have another system, you would feel that this Act, as it now stands, would go as far as to give you very fine trouble in co-ordination and making an arrangement of co-ordination under this Act, accounting-wise, etcetera?

MR. O'LEARY: It is a very large subject, sir, and I think we all appreciate -- I think our answer must be yes, that we would anticipate a great deal of difficulty. It seems to me there are two completely sorts of animals: One is an insurer. Whether a private profit-making company or not, they are in the business of providing insurance and reimbursement for expenses. The other, our type of organization, is in the business of providing service directly and it seems to me that while our areas of interest and concern overlap, to some extent, there are very wide areas that are going to concern the insurance people that won't concern us, and vice-versa. And the problem of applying a common denominator in a blanket organization that includes both types is going to be difficult, I think.

MR. MAJOR: There is somewhere between 40 and



1 50 so-called service organizations, non-profit service
2 organizations in this Province and practically all of those
3 organizations, in getting together, they agree that the methods
4 that could be devised under Medical Carriers Incorporated,
5 once they do become established, could be reasonable for them
6 to carry on. Medical Carriers Incorporated will, of necessity,
7 be an organization that is going to have to do a lot of
8 negotiation. Do you think it would be possible for your
9 organization to take part in those negotiations, to find common
10 ground?

11 MR. OSLER: I can only answer as I did
12 before, sir. I think nothing is impossible and we can, no
13 doubt, find some sort of common ground and, no doubt, we can
14 enter those negotiations. But I say it is awkward and it would
15 be far more practical if, if you like, a parallel organization
16 were set up to encompass people like us. But that would be
17 preferable to having one organization that tries to encompass
18 both types of services.

19 MR. MAJOR: Fine, thank you. I just have one
20 or two points for clarification. I think that the statement
21 was made by one of you gentlemen that your organization could
22 not charge a fee for medical services; then you also said that
23 if there was an emergency that came to the door of your
24 Association, you would look after it. If the patient came
25 to your door and was quite well able to pay a fee and was not



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MR. OLIVER: I can only answer as I did before, sir. I think nothing is impossible and we can, no doubt, find some sort of common ground and, no doubt, we can enter those negotiations. But I say it is awkward and it would be far more practical if, if you like, a parallel organization were set up to encompass people like us. But that would be preferable to having one organization that tries to encompass both types of services.

MR. MAJOR: Mine, thank you. I just have one or two points for clarification. I think that the statement was made by one of your gentlemen that your organization could not charge a fee for medical services; then you also said that if there was an emergency that came to the door of your Association, you would look after it. If the patient came to your door and was quite well able to pay a fee and was not



1 a member of your Association, you would not charge him a fee?

2 DR. FERRIER: The answer being, and we have,
3 in fact -- "Sorry, this program is for subscribers." In the
4 event of an emergency, which would make it impossible to
5 transfer this patient, then we provide the service. As yet,
6 we haven't faced the problem whether this person should be
7 billed for this emergency service. It has not been done yet.

8 THE CHAIRMAN: It has been pointed out that
9 they do bill but it is billed under the branch or division of
10 this Association.

11 DR. FERRIER: Yes.

12 THE CHAIRMAN: So presumably if you do it to
13 the Workmen's Compensation Board, you can do it to the
14 individual on the same basis.

15 MR. MAJOR: Then, have you had the experience
16 of making a bill to an individual yet?

17 DR. FERRIER: That is correct.

18 MR. MAJOR: You have said that in emergent
19 conditions in places in North America, you would pay the
20 subscriber's bill. Would you pay the bill as charged by the
21 physician? Supposing the service rendered by the physician
22 in place X listed under the O.M.A. schedule is \$200.00; would
23 you pay that chap \$600.00 if that was his bill?

24 DR. FERRIER: I think the answer is not quite
25 clear. We would have to go to negotiation with this

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1 physician and we would attempt to pay the O.M.A. schedule.

2 MR. MAJOR: Have you had this experience, yet?

3 DR. FERRIER: No.

4 MR. MAJOR: Or what would you do if you had it?

5 If a patient of your clinic, your Association decides, on his
6 own, to go to Mayo Brothers, what would you do with that?

7 DR. FERRIER: We would say that this is the
8 choice of the individual and we would not be obligated.

9 MR. MAJOR: Those services are not a benefit
10 of your agreement?

11 DR. FERRIER: That is correct.

12 MR. MAJOR: Thank you. That is all.

13 THE CHAIRMAN: I have been trying to find a
14 quotation I have in mind. It seems to me that the Minister
15 of Health said that, in his opinion, one of the things that
16 should be available in a medical services insurance plan is
17 that there should be freedom of choice on the part of a patient
18 for the physician. Your Association would not entirely agree
19 with this because you do not have freedom of choice?

20 MR. OSLER: There is freedom of choice in this
21 way, sir: As it has operated in most cases, the employers of
22 the persons who form our groups present two alternatives to
23 their employees. They can take some form of insurance scheme
24 in which they have complete freedom to go to anybody, or they
25 can take us, in which case they are limited initially to a



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1 group of thirteen or fourteen physicians.

2 THE CHAIRMAN: Yes. But once they participate
3 in your group, they no longer have freedom of choice?

4 MR. OSLER: We do not bind them for long.

5 We get them a year at a time, so they can re-elect. But while
6 subscribers, they are confined to our medical group.

7 THE CHAIRMAN: They couldn't benefit from your
8 plan if you exercised the freedom of choice beyond what was
9 available to them through your plan?

10 MR. OSLER: That is correct.

11 MR. BARKER: They do make a choice originally.

12 THE CHAIRMAN: Only the choice to participate
13 in the plan or not?

14 MR. BARKER: And that choice is that they
15 want the medical services of the doctors in the plan.

16 THE CHAIRMAN: This applies to P.S.I., too,
17 that they are limited to the doctors that participate in it.

18 MR. MAJOR: No, sir, because by the time they
19 go to the participating doctor, they might not like the red
20 tie he has got on and this is the same thing in this
21 association.

22 MR. BARKER: The people who choose P.S.I. in
23 Sault Ste. Marie were deprived of the services of every doctor
24 in the Soo . . .

25 MR. MAJOR: They had the freedom of choice.



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1 MISS CARPENTER: Where there is only one group
2 of practising physicians, this would hold the same. In a
3 small town where physicians decide to practise in a group
4 and there is only one group, they must go to that group.

5 THE CHAIRMAN: Yes.

6 MISS CARPENTER: So this principle is not
7 unique in Canada.

8 MR. WHITNEY: On that, we might get some
9 help on these periodic health examinations. From your experience
10 have you had them lining up at the door? Do they resort to
11 this? What is your experience on that, because it is an
12 exception in the Bill and it causes some concern.

13 DR. FERRIER: We have already seen two-thirds
14 of the subscribers in four months, a great number for so-called
15 checkup examinations, which might be considered in this
16 area of periodic examination.

17 I must say that the staff has been more than
18 impressed that these have virtually all been necessary and
19 the amount of disease uncovered has been fantastic. When
20 people come for a checkup, on questioning you find that there
21 are things that have been bothering them that led them to
22 ask for the checkup, in the first place, and they are very
23 valuable.

24 MR. WHITNEY: Do you have to have a pretty
25 strong program to get them in?

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of practicing physicians, this would hold the same. In a small town where physicians decide to practice in a group and there is only one group, they must go to that group.

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1 DR. FERRIER: No, not in this group. Two
2 thirds or three-quarters of the entire subscribers have at
3 least had a medical.

4 MR. WHITNEY: Without pushing them?

5 DR. FERRIER: Nothing, except a newsletter which
6 in general advocated preventive examinations and coming to
7 see a doctor early in the course of illness.

8 MR. WHITNEY: On the three hundred that
9 retired, have you granted them waiver premiums?

10 DR. FERRIER: Yes.

11 DR. BUTT: I just want to follow this up. You
12 mentioned that when they came for a checkup there were things
13 that were bothering them?

14 DR. FERRIER: Yes. On questioning, you either
15 find symptoms or findings.

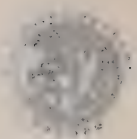
16 MR. NAYLOR: Would there be many in this
17 number you have seen that came simply just for a health
18 examination?

19 DR. FERRIER: Yes.

20 MR. NAYLOR: Just to be sure they are okay?

21 DR. FERRIER: But we were surprised at the
22 number who see they can receive a checkup and, on investigation,
23 you find symptoms.

24 MR. NAYLOR: Is there any limit on the frequency
25 -- they can come just for a periodic examination?



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1 DR. FERRIER: No. They simply call for an
2 appointment.

3 MRS. AYLEN: Does that put any pressure on
4 the hospital beds?

5 DR. FERRIER: No.

6 MRS. AYLEN: Are the waiting lists down in the
7 hospital?

8 DR. FERRIER: The waiting lists are down some-
9 what, but there have been additional beds. I think it would
10 be very interesting to see statistics, when we have them
11 complete, on the portion of the population we care for, as
12 compared to the rest of the population.

13 MRS. AYLEN: Yes. I think that would be
14 very interesting.

15 MISS McARTHUR: Is this a matter of concern
16 to the participating doctors, that there was this large number,
17 or do they feel this is something that they can control, having
18 seen the person at the first. Would see this drop off over
19 a period of time?

20 DR. FERRIER: Yes.

21 THE CHAIRMAN: Are there any further questions
22 from any members of the Enquiry?

23 Do you have any further statements?

24 MR. OSLER: I would like to be clear, before
25 we conclude, as to what we are now expected to supply. We have



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we conclude, as to what we are now expected to supply. We have



1 undertaken to supply a copy of our contract, particulars of
2 the by-laws pertaining to election and eligibility as members
3 and directors and a list of the current board of directors.
4 Is there anything else?

5 THE CHAIRMAN: That is all I recall -- and
6 a copy of your invoices, how you would charge.

7 MR. WHITNEY: I think if anything occurs to
8 you out of this meeting this morning that you want to support,
9 you are entitled to. Nothing occurs to me.

10 MR. OSLER: You have no objection to some
11 slight supplementary brief to accompany these documents?

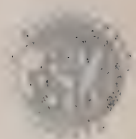
12 THE CHAIRMAN: No. It is our desire to get
13 all the information which will be helpful and you can feel
14 free to submit it.

15 MR. SIMON: The number of retired people -- I
16 think he said 300 -- those are all from Algoma Steel?

17 MR. BARKER: The originals were, yes. I said
18 the 300 persons were already on retirement. The retirement
19 age is now reduced, so there will be more retirement people
20 in the future than in the past.

21 MR. SIMON: Algoma Steel being the largest
22 employer in Sault Ste. Marie, do you feel that you have a
23 fair proportion of the older people in the Soo that you are
24 taking care of?

25 MR. BARKER: I wouldn't say that -- in comparison



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fair proportion of the older people in the 300 that you are

taking care of?

MR. BARKER: I wouldn't say that -- in comparison



1 to any other employer, yes.

2 DR. BUTT: Percentage-wise of the overall
3 population of the area, would you be carrying more of the
4 older-age group?

5 MR. BARKER: The approximate population is
6 65,000. We have got about 28,000 of that population which
7 works for Algoma Steel.

8 MR. SIMON: Including the families?

9 MR. BARKER: Almost half the population.

10 THE CHAIRMAN: You only have 15,000 subscribers?

11 MR. BARKER: Yes.

12 DR. BUTT: And yet three hundred of those
13 are retired or over age 65?

14 MR. BARKER: No. 300 are people already on
15 retirement when this program went into effect. A good many
16 have retired since that time.

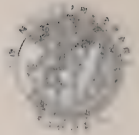
17 THE CHAIRMAN: They are not counted as
18 subscribers then? Are they included in the 15,000?

19 MR. BARKER: Yes.

6 20 MR. SIMON: Additional to the 300?

21 MR. BARKER: I couldn't tell you how many
22 additional there are.

23 DR. BUTT: The proportion over 65 that your
24 organization is now carrying, this is what we would like to
25 know.



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1 MR. WHITNEY: The 15,000, does that include
2 the dependents?

3 MR. BARKER: Yes.

4 THE CHAIRMAN: The employer does not make
5 any contribution for the ones who are over 65?

6 DR. FERRIER: No.

7 DR. BUTT: Those who are laid off work, do you
8 carry them premium-free?

9 MR. BARKER: No. But they do have the coverage
10 if they desire it, which they do not have otherwise. This is
11 one of the things that made us enter this type of program.

12 DR. BUTT: You say they have the coverage?

13 MR. BARKER: That is correct.

14 DR. BUTT: But they are premium-free?

15 MR. BARKER: No.

16 DR. BUTT: They pay a premium?

17 MR. BARKER: Yes, they pay a premium.

18 THE CHAIRMAN: Thank you very much, gentlemen.

19 MR. OSLER: May I just add about two sentences
20 before we are dismissed, Mr. Chairman.

21 One of the things that we see as a virtue in
22 this program is that it is, to some extent, experimental. They
23 are having similar programs in other countries, but not any
24 comparable in this country. There are differences of opinion
25 as to whether this is the right way to go about this or not.



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5 But it is a sincere, bona fide experiment and it would seem
6 to us unfortunate if unduly narrowing this Bill were to
7 result in making it impossible for a person similarly inclined
8 to conduct similar experiments, in good faith. We think this
9 is a point that should be kept in mind by this Committee in
10 its recommendations, that to close a straight jacket, if you
11 like, on this kind of category could well result in a sort
12 of sterility that would make it very difficult to develop
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14 We feel that sufficient freedom should be
15 allowed for this sort of organization to flourish and others
16 who have similar schemes that seem to be practical and we
17 hope that they will be kept in mind by the Committee.

18 DR. BUTT: Since you have brought up other
19 countries, would you answer this. In Michigan, which is
20 fairly close to the Soo, do your subscribers pay a fee on a
21 visit to your clinic in Detroit?

22 MR. OSLER: When you say "your clinic", what
23 are you referring to?

24 DR. BUTT: To a similar clinic run by a union
25 in the same setup.



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1 DR. FERRIER: There is the U.A.W. program in
2 Detroit and there is no registration fee, as far as I know,
3 when you go. I think there are home call charges.

4 DR. BUTT: I happen to know that there is a
5 fee for every visit, and I think we should leave this, in
6 fairness to you. But, since you brought it up, this is
7 for clarification. I was wondering if you would feel that
8 you could, at some time, do this, or does this enter into your
9 thinking at all?

10 DR. FERRIER: This is probably not necessary
11 in general, although there have been plans, I know of, that
12 use it.

13 DR. BUTT: You brought this up and this is
14 how they developed and this is what they found.

15 MR. OSLER: We haven't found it necessary, so
16 far. We do not contemplate it.

17 THE CHAIRMAN: Thank you very much, gentlemen.

18
19 ---Luncheon Adjournment.
20
21
22
23
24
25



DR. FENNER: There is the U.A.W. program in

Detroit and there is no registration fee, as far as I know,

when you go. I think there are home call charges.

DR. BUTT: I happen to know that there is a

fee for every visit, and I think we should leave this, in

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for clarification. I was wondering if you would feel that

you could, at some time, do this, or does this enter into your

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THE CHAIRMAN: Thank you very much, gentlemen.



AG/dpw 1 --- On resuming at 2:15 p.m.

2 THE CHAIRMAN: Ladies and gentlemen: just before
3 we call on the delegation that's here, and because this is the
4 delegation from the Ontario Society on Aging, I think it would
5 be appropriate for me to correct what I'm reported to have
6 stated, as recorded in today's issue of the "Daily Star,"
7 which says the Chairman of the Committee studying Ontario's
8 proposed Medicare Plan confirmed today that old, sick people
9 will have to pay more for medical insurance than younger,
10 healthy ones.

11 This is not exactly as the statement was made,
12 and it's not, in my own interpretation of the Act, accurate.
13 The Act does suggest that there would be a maximum premium
14 established, but that the minimum policy may be sold to any
15 group less than the maximum premium, and the \$180 that's
16 mentioned has not been established as what the maximum premium
17 would be.

18 I don't know whether the press wishes to do
19 anything or not about this, but I thought it would be worth-
20 while mentioning that, and I think it's particularly appro-
21 priate in view of the delegation that's appearing here before
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23 I assume this is the delegation of the Ontario
24 Society on Aging. Have you had an opportunity to read the
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1 DR. BEATTIE: Yes, we have.

2 THE CHAIRMAN: Then, whoever is to be your
3 spokesman, would you introduce yourself, and then introduce
4 your colleagues?

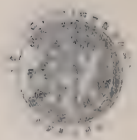
5
6 SUBMISSION OF THE ONTARIO SOCIETY ON AGING

7 Appearances: Miss Mary E. Macfarland
8 Dr. Samuel Beattie
9 Dr. L.A. Pequegnat
10 Dr. B.T. Dale

11 DR. BEATTIE: Mr. Chairman, we thank you for
12 the opportunity of appearing before this Committee and making
13 a case, as we do in our report.

14 We represent what's called the Ontario Society
15 on Aging, and at the present time it's called the Section on
16 the Aging of the Ontario Welfare Council. This report, how-
17 ever, was drawn up at a time when we had the first title,
18 namely, the Ontario Society on Aging, and we'll stand behind
19 it and sponsor it.

20 Our group today is composed of four people,
21 our Chairman, Miss Macfarland, who, until recently, was the
22 head of nurses in the Toronto General Hospital; on her right,
23 Dr. Dale, who is the Medical Officer of Health of Wellington
24 County; on my left is Dr. Pequegnat, who is the Director of
25 the Home Care Program at the Department of Health in Toronto,
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and a pilot project which they have in mind. Our Chairman for



1 this meeting will be Miss Macfarland, as I said, and she is
2 now prepared, I believe, to make a report on the pith and
3 marrow of our report, so I would ask Miss Macfarland to do so.

4 MISS MACFARLAND: Thank you very much. Mr.
5 Chairman and members of the Medical Services Insurance Enquiry
6 Committee: it's a real privilege for me to be here this after-
7 noon. I feel, however, that I should say that I'm not the
8 person, Mrs. McHale, our President, is, and we regret very much
9 that she's not able to be here, because of illness, and I
10 would ask the indulgence of the Committee while I read the
11 Problem, on page 3, as well as the Recommendations and Conclu-
12 sions.

13 The problem has been stated as:

14 "The Ontario Society on Aging is convinced that,
15 in order to fulfil the health needs of the
16 older citizens of this province, the following
17 considerations must be taken into account in
18 any legislation respecting the provision of
19 medical services for the people of Ontario.

20 "Over the past few years the volume of chronic
21 disease and disability has been increasing at
22 an alarming rate throughout Canada. The main
23 cause for this has been a marked change in the
24 number and proportion of older people in the
25 population with a concomitant disease in long



1 term illness. Industrialization and urbaniza-
2 tion have compounded all of the difficulties
3 faced by the elderly.

4 "Conditions such as diabetes, heart condition,
5 cancer, mental disorders, arthritis and rheuma-
6 tism, and other such threats to health and well-
7 being, cannot be controlled without planned and
8 sustained long term efforts. The number of
9 elderly persons will certainly increase; the
10 average age of admission to hospitals will
11 become still higher and the length of stay
12 progressively longer. The extension of insti-
13 tutional accommodation as the only control
14 measure will not provide a solution.

15 "Chronic illness and disability are of such
16 major importance to public health that all
17 aspects of control must be considered. The key
18 to the health problems arising from an aging
19 population lies in the effective organization
20 and co-ordination of all phases of health
21 services, namely: prevention, early detection,
22 treatment, rehabilitation and research.

23 "It is also imperative to recognize that the
24 health problems of the aged are much broader
25 than merely the provision of adequate health



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5 aged are so closely interrelated that they are
6 increasingly referred to as socio-medical.
7 Close co-operation of all the official and
8 voluntary agencies concerned with the aged is
9 necessary both at the provincial and local
10 level."

11 The Conclusions and Recommendations are set out
12 on page 2:

13 "Recognition must be given to the inescapable
14 responsibility of the Ontario Government to
15 provide adequate health care for the growing
16 aged population of this province and
17 increasing leadership must be forthcoming in
18 assessing and dealing with the problems of the
19 aged.

20 "In presenting this brief to the Medical
21 Services Insurance Enquiry, the Ontario Society
22 on Aging sincerely hopes that the following
23 recommendations will be converted into specific
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1 and healthy a way as possible:

2 "Comprehensive health insurance coverage within
3 the means of all older people be made available
4 without delay.

5 "The Provincial Department of Health establish
6 a branch of aging and chronic illness.

7 "The Provincial Government give immediate
8 consideration to the extension of home care
9 programmes through local health departments.

10 "Provision be made for in-patient and out-
11 patient coverage for rehabilitation services in
12 hospitals and in rehabilitation centres.

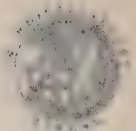
13 "Further aid be given to research to explore
14 the nature of the aging process and to support
15 epidemiological studies.

16 "Co-ordination of effort in the field of aging
17 be encouraged by setting up a provincial inter-
18 departmental committee on aging and local senior
19 citizens councils."

20 Thank you very much, sir. This is the presen-
21 tation from the brief.

22 THE CHAIRMAN: Thank you. Some of the members
23 of our Enquiry wish to ask you questions.

24 DR. BUTT: Well, I certainly appreciate the
25 brief, and certainly the people on it. It has been



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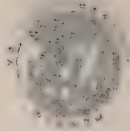
2 Just for clarification, on page 2, Section (e):

3 "---research to explore the nature of the
4 aging process and to support epidemiological
5 studies."

6 I'm just wondering in a little more detail what
7 you had in mind. There's a geriatric program out at the
8 Western Hospital. Is this the type of thing you have in mind,
9 or something more specific? Is it the same type of thing that
10 the Heart Foundation is carrying on?

11 DR. DALE: Not necessarily, Mr. Chairman. I
12 feel that there's a need for support of different studies.
13 For instance, I have with me an article on my own study which
14 I conducted in last October, 1963, where, through my clinical
15 project, I have examined about 760 people within two days of
16 clinic for adults, and they went through different tests,
17 blood tests, urine tests, x-ray and blood-pressure tests, and
18 we've detected quite a few undiagnosed conditions which
19 weren't known to the people themselves, and weren't known to
20 their family physicians.

21 They were detected in such an early stage that,
22 of course, chances for those people are much better for treat-
23 ment, and we feel that this type of research, this type of
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ment, and we feel that this type of research, this type of

early detection, this type of mass screening, and mass

epidemiological studies, which could be supported by the



1 Government, could be of tremendous value in order to make
2 early diagnoses and early treatment, and also, of course,
3 prevention against chronic conditions.

4 DR. BUTT: Thank you very much. Then you went
5 on with the problem:

6 "---prevention, early detection, treatment,
7 rehabilitation and research."

8 This is the phase of research which you have in
9 mind; is that right?

10 DR. DALE: That's right.

11 DR. BUTT: When you talk about rehabilitation
12 on the bottom of page 3, is there such a thing in rehabilita-
13 tion as utilization of the older people in the economy, or
14 anything like that been gone into in working it out at the
15 sociological level?

16 DR. DALE: I suppose so. Of course, I'm
17 speaking for the rural area, where you can see the people
18 who could benefit from any type of rehabilitation, or restora-
19 tion to health, through bedside nursing; through physiotherapy;
20 and through many other means which aren't provided at present.

21 DR. BUTT: The only other question that comes
22 up, I guess Dr. Pequegnat would be better able to tell us
23 about it, the home care. Perhaps you could tell us a little
24 about it: how it's going; what it means, and what the price
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23 about it, the home care. Perhaps you could tell us a little

24 about it: how it's going; what it means, and what the price

25 might be?



1 DR. PEQUEGNAT: We have, for a matter of close
2 to six years, been carrying on a program, which is still a
3 pilot program, as it's applied to a limited area, and with a
4 limited amount of money, and it's related only, as I said, to
5 a limited area within the City of Toronto only; not Metropoli-
6 tan, by any means.

7 In that period of time we have had about 390
8 people pass through our hands so far as the original program
9 is concerned, and by original I mean one without hospital
10 connotation.

11 There's a second portion been added, by which
12 we take people out of two hospitals before the time they would
13 be normally discharged, and try out the practicability of
2 14 applying in the home care of a quality to replace that for
15 which they would otherwise have to remain in a hospital bed,
16 at high cost. We can do it more economically in the home.

17 It has now gone well over 300, and we're still
18 carrying on, as we await the final answer as to where we go
19 from here.

20 The economy is quite evident in Part 2 of the
21 program. It's much easier to explain than in Part 1, but
22 there's a good equation, even in the original part of the
23 program where we can take care of people in their home surroun-
24 dings, and defer, or prevent institutionalization, if that
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1 As far as taking them out of hospital is
2 concerned, we've had a certain percentage, namely, we find
3 that the average stay of people is probably 36.5 days, whereas
4 the estimated first stay in hospital would have been one of
5 some 20 days, according to the best estimate placed on each
6 individual patient by the physician, either in the home, or by
7 the hospital staff.

8 When you equate these two, you find that it can
9 be written in terms of dollars and cents as far as maintenance
10 is concerned. It can even be written in terms of hospital bed
11 building.

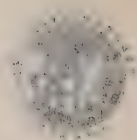
12 One has to be careful in judging use of a
13 hospital bed here, because immediately it's empty there's
14 another patient ready to go in, but the long-term viewpoint is
15 very sound, and shows a great economy.

16 Now, we select these patients. It's not appli-
17 cable to a very high percentage of patients, but in the aggre-
18 gate it's applicable to enough patients to make it worthwhile,
19 particularly in a metropolitan community, and the same thing
20 might be true, to a lesser extent, in other communities.

21 This is just the skeleton.

22 DR. BUTT: Well, on the skeleton you would be
23 able to supply some figures that we could use?

24 DR. PEQUEGNAT: Oh, yes, we're completing our
25 five-year report now as a matter of fact, and just before



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2 what these mean in terms of our future operation.

3 DR. BUTT: In dollars and cents?

4 DR. PEQUEGNAT: Yes, and also it's very hard to
5 put a value on the care of a person at home, and while it's
6 on an unpriced value, it's there.

7 DR. BUTT: Well, we would appreciate it if you
8 could send this in at a later date.

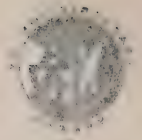
9 DR. PEQUEGNAT: We've had this relating, so far
10 as the initial program, the original program is concerned,
11 only to two of eight health districts, and it relates to about
12 160,000 people.

13 Now, the hospital program is related to the
14 people in two of Toronto's central hospitals, who live any-
15 where within the City of Toronto. The limitation here is one
16 of the number of hospitals we selected. In the first case it
17 was the number of the population to which it applied.

18 DR. BUTT: Is there any relationship between
19 the geographical location of the person's residence and the
20 hospital he goes to?

21 DR. PEQUEGNAT: Only that he must be within the
22 City of Toronto, and I can tell you this, that in these two
23 hospitals about 43% of the population comes out of Metropolitan
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1 live outside Metro, and divide it, it's somewhat less than
2 15%, but the 85 or 86 per cent which remains splits itself
3 pretty evenly between that which is Toronto and that which is
4 non-Toronto within Metro, about 43% each.

5 You see, the family complex is different. As
6 we go on, we may find as we move out into the metropolitan
7 area, as we hope to, that it will change.

8 DR. DALE: We've completed a study on home
9 care in rural areas, so I may leave that with you.

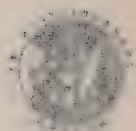
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11 MISS McARTHUR: I don't think I have too many
12 questions. I thought the brief made the point very pointedly,
13 that the delegation is enunciating a philosophy that looks
14 towards greater coverage than Bill 163 presents at this time,
15 and places the problem very clearly.

16 On page 7, Recommendation 18, the recommenda-
17 tion suggests that home care programs should be given imme-
18 diate consideration through local health departments, and
19 does this indicate that they feel that this is the most
20 desirable way to accomplish their purpose, the only way, or
21 do they see alternatives?

22 That is, perhaps, one of my first questions.

23 DR. PEQUEGNAT: I don't think the intent
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1 through another agency, a voluntary agency, nor should it
2 preclude that which is more appropriate for the future, but
3 it's still that the initiation might very well come through
4 local health departments. It's a health matter, home care.

5 MISS McARTHUR: So your philosophy is greater
6 than your means of implementation of that philosophy, and this
7 is one means of implementing it?

8 DR. PEQUEGNAT: Let's by no means lose sight of
9 the fact that this is a health matter.

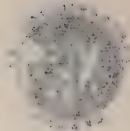
10 MISS McARTHUR: I remember one question that
11 was raised in my mind. It's on the same page. I must say I'm
12 being Miss Carpenter at the moment, as well as myself, Dr.
13 Hagey, and I'm trying to think of some things she would be
14 interested in.

15 In No. 17, in the last sentence:

16 "Such programmes would frequently prove more
17 beneficial and economical than care in hospital
18 or other institution."

19 And there are two questions that came to mind,
20 and one relates to cost.

21 Is it possible to give us a related cost,
22 although I would recognize from your philosophy the purpose
23 is not in saving money, it's in giving the best care, but is
24 there a difference in cost between home care and hospital
25 care?



through another agency, a voluntary agency, nor should it preclude that which is more appropriate for the future, but it's still that the initiation might very well come through local health departments. It's a health matter, home care.

MISS McARTHUR: So your philosophy is greater than your means of implementation of that philosophy, and this is one means of implementing it?

DR. FERGUSON: Let's by no means lose sight of the fact that this is a health matter.

MISS McARTHUR: I remember one question that was raised in my mind. It's on the same page. I must say I'm being Miss Carpenter at the moment, as well as myself, Dr. Hagay, and I'm trying to think of some things she would be interested in.

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1 DR. PEQUEGNAT: Yes, definitely.

2 MISS McARTHUR: And have you a figure to give
3 us?

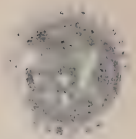
4 DR. PEQUEGNAT: I have a figure, and it's
5 written into Report No. 5, the fifth year's annual report,
6 and, as I say, every case is given an estimated number of
7 days of hospital care which has been saved by being sent home.

8 In other words, we say very definitely that
9 unless you can tell us that there's hospital saving, the
10 patient doesn't become part of this program.

11 We also say that the patient must have hospital-
12 ization insurance, not that the hospitalization is part of the
13 rates, but we do believe that it sets up one circumstance,
14 and that is that there's no ulterior reason on the part of the
15 patient for wanting to go home.

16 So as I said before, it relates only to a small
17 percentage of the population, and you would be surprised if I
18 gave you the low percentage, but in the aggregate it amounts
19 to a lot.

20 We had 195,000 admissions in the metropolitan
21 area in one hospital in a year. The average day's stay per
22 patient is 22.5, and, mark you, we carry home care a little
23 farther than the estimate given of the hospital days saved,
3 24 because our objective is a higher objective. It's rehabilita-
25 tion in a home setting, which the hospital could not hope to



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farther than the estimate given of the hospital days saved,

because our objective is a higher objective. It's rehabilitation

in a home setting, which the hospital could not hope to



1 accomplish.

2 But what does it matter if the cost is so much
3 lower? That seems to be the conviction everywhere. This
4 figures runs consistently through our sampling, that this is
5 65% of the days on home care, and that the average hospital
6 saving is \$615 per patient. From such a figure one takes
7 the cost of 34.5 days of home care, which is the average stay
8 on the home program, very much less, I might say, than that
9 reported from other centres doing like work, and we price that
10 at \$6.31 per day, for a net saving of \$381.

11 This represents the economy from this calcula-
12 tion, and then we've gone on to a larger potential, for the
13 whole of Metropolitan Toronto, and it's rather amazing that we
14 could release 27,000 hospital days each year.

15 MISS McARTHUR: As you see it in relation to
16 the present geographical area, or as you conceive it would be
17 if you had a whole program?

18 DR. PEQUEGNAT: In Toronto the 300 cases would
19 give us something like -- well, it would give us, let's say,
20 the difference between 34 and 22, which is 12 days. It's a
21 matter of a saving of 24 days.

22 MISS McARTHUR: You are conceiving what might
23 happen if we could think in terms of the comprehensive plan
24 in a larger urban area?

25 DR. PEQUEGNAT: Yes; one can see in saving

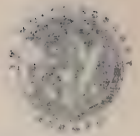


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1 alone, even before we have the courage to take out of hospital
2 certain types, all cases that we haven't the courage to take
3 out, yes, we can see the equivalent of a year of the occupancy
4 of 90 to 100 beds.

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MISS McARTHUR: I have one other comment,
Mr. Chairman. The Ontario Society on Aging, has it concerned
itself with other types of institutions other than acute
hospitals and home care in terms of the adequate care of
the people that are of your interest?

DR. PEQUEGNAT: I have another set of figures
in which it can be shown that the cost of services are no
greater than what probably would have been the experience
of the patients if there hadn't been home care in these
various types of units of care, hospitals, institutions,
nursing homes, or what-have-you. That applies to 45% of the
group and the other 55%, the question of placing others in
the home did not come into the picture.

MISS McARTHUR: The urgent need then in this
whole area is to plough some new ground and home care, you feel,
has a priority?

DR. PEQUEGNAT: May I have that again?

MISS McARTHUR: I was wondering whether the
brief was indicating that if energies had to be directed
towards the care of the group that you are concerned about,
that the energy should at this time be directed towards the
development of home care?

DR. PEQUEGNAT: Yes. You are perfectly right,
providing the home care is suitable and uniform, too.

MISS McARTHUR: When you speak of home care,



MISS McARTHUR: I have one other comment.

Dr. McGuinnat, the statistics which you have given me, I think, are very interesting. I think it is very interesting to find that in terms of the adequate care of hospitals and home care in terms of the adequate care of the people who are in need of care.

DR. McGUINNAT: I have another set of figures in which it can be shown that the cost of services are no greater than when they were in the hospitals. I think of the patients if there hadn't been home care in these various types of units of care, hospitals, institutions, nursing homes, etc., the question of placing others in the group and the other 5%, the question of placing others in the home did not come into the picture.

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DR. McGUINNAT: Yes. You are perfectly right, providing the home care is suitable and uniform, too.

MISS McARTHUR: When you speak of home care,



1 would you also include foster home care, for instance?

2 DR. PEQUEGNAT: We haven't yet, but we have
3 taken rooms, flats into consideration. The person is usually
4 living in some self-contained unit, small as it may be, or
5 a part of a family, a family group.

6 MISS McARTHUR: I have one more question,
7 Mr. Chairman. What place does the physician play in such
8 a program and to what extent has it been accepted by physicians
9 -- this program of home care?

10 DR. PEQUEGNAT: In a home care program there
11 must be, first of all, a condition which has medical super-
12 vision. The physician must be in the picture, small as his
13 actual attendance may be. We set this out in the letter
14 written to the physician. We expect at least one contact
15 per month. We have said that in so many words in a letter.
16 He is required to refer the case before we accept it. He is
17 the one by whose suggestion, or acquiescence, we discharge
18 the case. He writes the total prescription care -- I mean
19 more than the drug prescription -- the total prescription
20 of care. He modifies it and amends it. He is the central
21 figure.

22 MISS McARTHUR: To that extent, even though
23 Bill 163 might stand as it is now or might not, which is
24 something for the future, Bill 163 would, to some extent,
25 be supported to this program because it does define that the



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22. Bill 163 might stand as it is now or might not, which is

23. a question of the future, the program would be the same

24. as it is now. The program is the same in all respects



1 physician's service would be available?

2 DR. PEQUEGNAT: Yes. It makes the key person
3 the physician.

4 MISS McARTHUR: Those are my questions.

5 THE CHAIRMAN: In the study to which you
6 referred, relative to the number of days in hospital that
7 is saved through the home care, who estimates the time that
8 the patient would have been required to stay -- the attending
9 physician?

10 DR. PEQUEGNAT: Yes, the hospital staff and,
11 if possible, the physician who is about to resume the case
12 at home. The physician in charge at home has the right to
13 modify and change that estimate at will at any time.

14 MR. COULTER: I haven't too many questions
15 because some of mine have already been answered. In your
16 conclusions and recommendations "Comprehensive health insur-
17 ance coverage within the means of all older people be made
18 available without delay." I agree with this. But as Bill
19 163 is a medical bill and your expression here is "health",
20 how much besides home care would you like included in the
21 Bill, or do you think that should be included in the Bill?
22 For instance, health examinations?

23 DR. PEQUEGNAT: I pointed out, first of all,
24 that by the criteria which are set up for a guaranteed home
25 care, there was some discussion or controversy over it. I might

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1 say that we do not take a case under home care if there are
2 only two services because those services are, more often than
3 not, medical and nursing which, in our opinion, do not need
4 co-ordination. They have worked together so well for so long.
5 So it is over more than two services. There are other
6 criteria, such as the suitability of the home, the willing-
7 ness and the desire.

8 Up to the present time, and I do not say this
9 is going to be a final figure -- we have only been able to
10 take about two patients for every -- or one patient for every
11 two thousand of the population. We have not been able to
12 expose the program to mass publicity. We haven't even been
13 able to go after the doctors because I do not know of any
14 better way to discourage a doctor than to have them call up,
15 for example, when he has a patient and he is told that the
16 patient is just living over the balcony. It must refer to
17 more than just home care treatment.

18 THE CHAIRMAN: Mr. Coulter, wouldn't the
19 answer to your question be in the first recommendation, that
20 they are recommending comprehensive health insurance coverage
21 within the means of all older people be made available without
22 delay?

23 MR. COULTER: Yes, it does. But comprehensive,
24 to me, means everything and this could be quite costly. Does
25 this mean dollars and cents or does it mean physical places to



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1 carry out these programs?

2 THE CHAIRMAN: The question is really in the
3 first recommendation: how far do you go when you say "compreh-
4 ensive"?

5 DR. BUTT: You have even got, at the top of
6 page 8 "friendly visiting".

7 DR. PEQUEGNAT: We use them in the home care
8 program.

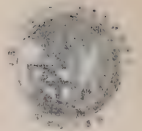
9 DR. BUTT: But do you feel the government should
10 pay for this as part of its scheme?

11 DR. PEQUEGNAT: That was the feeling of the
12 Committee.

13 DR. BUTT: Thank you.

14 MR. COULTER: My only concern, Mr. Chairman,
15 is that as the Bill now stands, or as it might be remodeled,
16 we would have trouble, I would think, recommending some of
17 these things under this particular Bill. Of course, you
18 can say to us that this is our problem. But, there is no
19 doubt in my mind that these things are needed and needed badly
20 across the province. I was just wondering if you had a
21 choice, what would you start off with as a base outside of
22 home and nursing care? If you have a second or third or
23 fourth choice?

24 DR. PEQUEGNAT: What can one add without opening
25 up the Bill, sir?



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1 MR. COULTER: For instance, would health
2 checkups once yearly or half-yearly be of assistance --
3 catching them before they become chronic?

4 DR. PEQUEGNAT: Among the many things, certainly.

5 DR. DALE: This is contained in our recommend-
6 ation of prevention and early detection of the disease, on
7 page 5.

8 THE CHAIRMAN: I think it is pretty evident
2 9 here, if you look at page 7(19), that their suggestion is
10 practically everything in the way of health treatment that
11 you can think of, almost.

12 MR. CASWELL: "Extended comprehensive . . ."

13 THE CHAIRMAN: Yes; even vocational counselling,
14 home-making, friendly visiting, et cetera. I am sorry,
15 Mr. Coulter. I do not wish to stop your questions.

16 MR. COULTER: It still befuddles me a little
17 bit because going back to 2(a), does this mean dollars and
18 cents? Is this dollars and cents they are talking about, or
19 is this a physical place to carry on some of these services
20 paid by the government? Because if it is dollars and cents,
21 I would submit that it is beyond the means of most of them.

22 DR. DALE: Of course, this is the idealistic
23 point of view and we realize that these things can't be done
24 immediately. But the recommendation which is contained here
25 suggests that there must be a beginning and the beginning,



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1 probably the best beginning, is with a home care program and
2 the establishment of preventive and early detection services.
3 We should not cover only the welfare patients which, at the
4 present time, I suppose some of the governmental agencies --
5 but which should be dealt with in the Health Department where
6 the preventive action is necessary to prevent chronic dis-
7 ability or to prevent economic distress.

8 Now, such a department, a branch of aging in
9 the Department of Health, should provide all these services
10 which you are thinking about, Mr. Chairman, like education,
11 like detection, like semi-annual examinations, diagnostic
12 in-patient and out-patient, in order to relieve the hospital
13 beds as well as in order to provide early detection and prevent-
14 ion of early chronic conditions and this, along with the home
15 care program which probably will then cover the present need,
16 urgent need for this type of comprehensive service.

17 Now, of course we realize that there are some
18 very expensive -- that they may need some physiotherapy and
19 some other services and all those things could be as well
20 organized with the government's sponsorship. What we really
21 mean is that we should direct certain services to the community
22 and build up community resources. This home care program
23 would not be hospital based, but community based and by building
24 up hospital resources we could provide certain services by
25 using all these other agencies which are already in operation



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1 in certain areas, which provide certain rehabilitation
2 procedures, like physiotherapy, and so on. But the emphasis
3 on prevention and early detection treatment and rehabilitation
4 is so important that it should not be omitted in any of
5 your endeavours to control these chronic disabilities which
6 we now find in our population.

7 You may have noticed that we know from statistics
8 that five times as many disabled persons are among people
9 over 65 years of age than among all other combined ages together.
10 So this is a growing problem. This is a growing and important
11 problem which must be faced very squarely because, otherwise,
12 we will, in future, find ourselves in the situation that we
13 will not be able to cope with these problems.

14 Our average lifespan is now between 70 and 74.
15 We realize that in this decade it may go to 80 years average
16 lifespan. We have more and more of these people and something
17 must be done now to think about the future and to prevent
18 all these disabilities and to cope with this situation, not
19 only through the Welfare Departments for these welfare
20 recipients, but by all the people who are needing this type
21 of help and service.

22 THE CHAIRMAN: Anything further, Mr. Coulter?

23 MR. COULTER: No, thank you Mr. Chairman.

24 THE CHAIRMAN: Mr. Simon?

25 MR. SIMON: On page 5 of your brief, item 12,



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only through the Welfare Departments for these welfare

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of help and service.

MR. COWLEY: No, thank you Mr. Chairman.

MR. SIMON: On page 5 of your brief, item 15,



1 you say "At present certain essential health services for this
2 group are administered by the Provincial Public Welfare
3 Department." What are these services that are provided by
4 the various provincial welfare departments and what do you
5 mean in the second sentence here "limit support to the
6 economically depressed."?

7 DR. DALE: Welfare recipients, mostly.

8 MR. SIMON: What are the benefits that are
9 provided for?

10 DR. DALE: All those under the Welfare Assist-
11 ance Act.

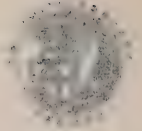
12 MR. SIMON: What form does this benefit take?

13 DR. DALE: Hospital services and medical
14 services for the welfare recipients.

15 MR. SIMON: I see -- just welfare recipients.
16 Then on page 8, item 20, you suggest "Either a comprehensive
17 health insurance scheme will be necessary, or a substantial
18 subsidy will be needed by a high proportion of older people."
19 In the first instance, I understand that you suggest a
20 government-run plan; is that right?

21 DR. DALE: Yes.

22 MR. SIMON: The second alternative, you suggest
23 a subsidy to needy people, needy older people. Can you be
24 more precise or definite in your ideas of what you mean by
25 "subsidy"? Would that be everybody or would there be a means



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1 test or would it be an income test, or what?

2 DR. DALE: We had this discussion with Dr.
3 Pequegnat before we arrived here. We feel really that we
4 are not advocating a means test.

5 MR. SIMON: You are against them?

6 DR. DALE: Yes, we are against them because
7 we do not want to divide people into different categories.
8 But, obviously, older people will need either comprehensive
9 health insurance or some kind of a subsidy. It is up to this
10 Committee to define how the government could provide a
11 subsidy.

12 MR. SIMON: Do you feel that a person who
13 is living on Old Age income, government Old Age income, can
14 support himself including medical insurance?

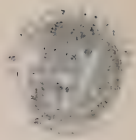
15 DR. DALE: We do not think so.

16 MR. SIMON: There would have to be some
17 yardstick?

18 DR. DALE: That is right.

19 THE CHAIRMAN: Do any of the other members have
20 any questions?

21 MRS. AYLEN: I want to come back to this.
22 You say you take a patient from the hospital. Do you still
23 have a liaison with the hospital from which a patient came?
24 For instance, if they need a blood test, do you go back to
25 the hospital to get that?



test or would it be an income test, or what?

DR. DALE: We had this discussion with Dr.

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For instance, if they need a blood test, do you go back to

the hospital to get that?



1 DR. PEQUEGNAT: During the period of the care?

2 MRS. AYLEN: Yes?

3 DR. PEQUEGNAT: Yes, frequently. We have
4 a contract whereby it will be done there and paid for as
5 though the person were remaining in the hospital. In other
6 words, this scheme is precisely like that of hospital insur-
7 ance in that while the Hospital Commission is not at the
8 moment paying for that, in lieu of hospitalization, his
9 expenses are being defrayed as though he was in the hospital
10 under contract.

11 MRS. AYLEN: That would include drugs as well?

12 DR. PEQUEGNAT: Yes.

13 MRS. AYLEN: And any appliances that you need.

14 If you need a fan, for instance, does that come from the
15 hospital?

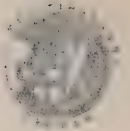
16 DR. PEQUEGNAT: Either that or from a renting
17 agency but is paid for by the program.

18 MRS. AYLEN: In most of these cases, I suppose
19 you select someone that you think is going to be rehabilitated?

3 20 DR. PEQUEGNAT: Yes.

21 MRS. AYLEN: Not a chronic case?

22 DR. PEQUEGNAT: There must be a reasonable
23 rehabilitation and it must be the type of case which fits
24 into the home and where the services that are going in can
25 be provided. There must be some person who can take care of



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rehabilitation and it must be the type of case which fits

into the home and where the services that are going in can

be provided. I think that is the main thing.



1 the patient in the off-hours.

2 MRS. AYLEN: Do you encounter any resistance?

3 DR. PEQUEGNAT: If there is resistance, the
4 patient does not go out. There is no compulsion.

5 MRS. AYLEN: Thank you.

6 DR. HAMILTON: Are these welfare patients only?

7 DR. PEQUEGNAT: No.

8 DR. HAMILTON: There is no means test?

9 DR. PEQUEGNAT: Anything from a day up can
10 be saved in the act of taking home.

11 DR. HAMILTON: Can rehabilitation services be
12 continued in the home?

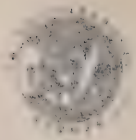
13 DR. PEQUEGNAT: Yes -- occupational therapy,
14 and it is paid for.

15 DR. HAMILTON: By the Hospital Services Commis-
16 sion?

17 DR. PEQUEGNAT: No -- by the fund that we have
18 at the moment, rather than by the Hospital Services Commission.

19 DR. HAMILTON: Things like blood tests would
20 be paid for by the Commission if they are done in the
21 hospital?

22 DR. PEQUEGNAT: No. If they are done in the
23 hospital, not only in the home. In other words, what we are
24 doing is we are merely setting up a replica of the in-patient
25 services carried on by the Hospital Services Commission, through



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19 DR. HAMILTON: Things like blood tests would
20 be paid for by the Commission if they are done in the
21 hospital, not only in the home. In other words, what we are
22 doing is we are really setting up a system of care in the home
23 which is similar to the Hospital Services Commission.



1 the insurance, but we are doing it in the home by the money
2 coming out of a fund other than that of the fund that the
3 Commission has collected.

4 THE CHAIRMAN: Is it fair to ask where this
5 fund comes from?

6 DR. PEQUEGNAT: At the moment, it is coming
7 from the Federal health grants in aid. So far as the original
8 program is concerned, the Board of Health has taken care of
9 that and so far as the expansion program, this hospital part
10 of the program is concerned, there is a small margin coming
11 from the Commission as it presumes to match the contribution
12 of the Board of Health.

13 DR. HAMILTON: You, therefore, pay for any
14 diagnostic tests that will be done?

15 DR. PEQUEGNAT: Yes.

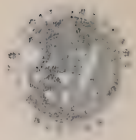
16 DR. HAMILTON: Or any therapy required in the
17 home?

18 DR. PEQUEGNAT: Yes.

19 DR. HAMILTON: Out of a special fund you have
20 at your disposal?

21 DR. PEQUEGNAT: Yes. Anything which is
22 related to the condition with which the patient was discharged.

23 DR. HAMILTON: Then may I ask you, Dr. Pequegnat,
24 does the cost of \$6.50 per day cover the cost of drugs, any
25 diagnostic tests that must be done and physical or other kinds



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related to the hospital and which is not covered by the

DR. HAMILTON: Then may I ask you, Dr. Pedregnat,

does the cost of \$6.50 per day cover the cost of drugs, any

diagnostic tests that will be done and therapy that is



1 of special therapy?

2 DR. PEQUEGNAT: Yes.

3 DR. HAMILTON: And nursing?

4 DR. PEQUEGNAT: There is their voluntary
5 services, including visiting nursing. Occupational therapy
6 and speech therapy, home aid or home-making, drugs, supplies,
7 transportation, anything which is incidental to the care
8 of that person in the home.

9 DR. HAMILTON: At \$6.50 per day?

10 DR. PEQUEGNAT: That was our experience.

11 MISS McARTHUR: The funds that are available
12 are available on a research of project basis with no guarantee
13 of continuity for the future?

14 DR. PEQUEGNAT: That is right, no guarantee
15 of long-term continuance.

16 THE CHAIRMAN: The name of your Society is the
17 Ontario Society on Aging. To what extent are you active
18 throughout the province?

19 DR. PEQUEGNAT: I will have that answered
20 by people who are more directly concerned with that.

21 MISS MACFARLAND: The Ontario Society on Aging,
22 I think, is known throughout the province very well. A good
23 many of the meetings are held in Toronto but the Society is
24 desirous of changing that, even, and holding their meetings
25 in areas where they will become better known in the future.



DR. RICHMOND: Yes.

DR. HAMILTON: And nursing?

DR. RICHMOND: There is their voluntary

services, including visiting nursing. Occupational therapy
and speech therapy, home aid or home-making, drugs, supplies,
transportation, anything which is incidental to the care
of that person in the home.

DR. HAMILTON: At \$5.00 per day?

DR. RICHMOND: That was our experience.

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DR. RICHMOND: That is right, no guarantee

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many of the meetings are held in Toronto but the Society is
desirous of changing that, even, and holding their meetings
in areas where they will become better known in the future.



1 I do not know that I am quite prepared to say just what the
2 future will be, because as Dr. Beattie said, the Ontario
3 Society on Aging, as recently as November 1963, became the
4 section on aging in the Ontario Welfare Council. We feel
5 that the amalgamation will prevent some overlapping, but it
6 is desirous that the Society be as active as it has in the
7 past five or six years. But it reached into all parts of
8 Ontario. It probably is better known in the larger cities
9 than other places. But I think it is well known.

10 THE CHAIRMAN: Do any of the other members
11 of the Enquiry have any questions? Are there any statements
12 that you would care to make?

13 MISS MACFARLAND: We are very appreciative
14 of being able to come here this afternoon and meet the members
15 of this Committee and for the courteous hearing that you
16 have given us.

17 THE CHAIRMAN: I am confident that all members
18 of the Enquiry recognize that you are struggling here with
19 a major problem and I think that you have very well presented
20 your concern about it.

21 DR. PEQUEGNAT: I do not want to leave the
22 impression a home care program is not a program for the aged
23 alone. A very high percentage of the clientele of the
24 home care is from among the population which is 60 years and
25 up but it could be at any age.



1 MR. SIMON: What do you consider to be old?

2 DR. PEQUEGNAT: I would like somebody else to
3 answer that.

4 THE CHAIRMAN: Thank you very much, gentlemen.

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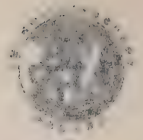
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MR. SIMON: What do you consider to be old?

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Answer that.

THE CHAIRMAN: Thank you very much, gentlemen.

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1 SUBMISSION OF THE CANADIAN ARTHRITIS AND RHEUMATISM
2 SOCIETY, ONTARIO DIVISION

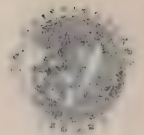
3 Appearances: Dr. M.J. Swanson
4 Dr. H.A. Smythe
5 Dr. J.D. Pearson

6 DR. SWANSON: I'm the Medical Director. We
7 have selected Dr. Smythe as our most eloquent member, who will
8 present the brief to you.

9 DR. SMYTHE: Yes. According to your instruc-
10 tions, you've read the brief, and I'll concentrate, therefore,
11 on several points we want to make.

12 First of all, this brief has been presented by
13 the Canadian Arthritis and Rheumatism Society. Therefore,
14 we're talking on behalf of the patients who have no other
15 spokesmen. We also in our position have acquired a great deal
16 of experience of designing and administering various forms of
17 treatment, and particularly in view of some of the discussion
18 we've just heard, perhaps we might comment on our third recom-
19 mendation, and talk about the economics, and the value of
20 different designs of treatment programs.

21 Now, the main part of our brief is contained in
22 the first two of the summarized recommendations on page 2,
23 which briefly states that in our belief physiotherapy and
24 occupational therapy should be given to patients, not only in
25 hospital, as an insured benefit under Bill 163 under certain
circumstances.



MEMORANDUM OF THE CANADIAN ASSOCIATION OF MEDICAL REPORTERS

SOCIETY, ONTARIO DIVISION

Presented by: Dr. W. J. Pearson
Dr. H. A. Smith
Dr. J. D. Pearson

DR. SWANSON: I'm the Medical Director. We

have selected Dr. Smythe as our most eloquent member, who will
present the brief to you.

DR. SMYTHE: Yes. According to your instructions,

first, you've read the brief, and I'll summarize, secondly,
on several points we want to make.

First of all, this brief has been presented by

the Canadian Association of Medical Reporters, the Ontario

branch of the Association, and I'll summarize, secondly,

we've looked at the brief, and I'll summarize, secondly,

of experience of the various and administrative bodies of

treatment, and particularly in view of some of the discussion

which we've heard, and we also want to make a point of

mentioning, and talk about the economics, and the value of

different designs of treatment programs.

Now, the main part of our brief is contained in

the first two of the summarized recommendations on page 2,

which briefly states that in our belief physiotherapy and

occupational therapy should be given to patients, and that in

hospitals, as an insured benefit under Bill 103, under the

circumstances



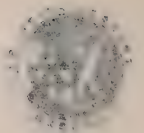
1 Now, we recognize that this Committee has
2 concerned itself chiefly with re-writing one particular Bill,
3 designed chiefly to provide medical services, and we're asking
4 for something which is not specifically in the care of doctors.

5 There are reasons, good reasons, for not trying
6 to broaden this Bill too much, and trying to include too much,
7 and there must be great care given to what items might be
8 included under it. I think that our recommendations are
9 within the terms of reference of the Bill as its presently
10 described.

11 As we say in paragraph (E) on page 4, the
12 terms of reference of the Bill state that, or define medical
13 services insurance as a contract whereby a resident is covered
14 for medical or surgical care or service or the cost or a por-
15 tion thereof when rendered to such resident and his dependants
16 by or under the direction of a physician, and the kind of
17 physiotherapy and occupational therapy that we're talking
18 about is that which is rendered under the close supervision of
19 a physician.

20 Now, this is for several reasons. From the
21 point of view of administration, it makes it easier to write
22 this into the Act, but also we believe it's necessary
23 medically.

24 To go back a bit, we've been operating special
25 rheumatic disease treatment units at the Veterans' Hospital



Now, we recognize that this Committee has

concerned itself with the medical profession, and we're looking for something which is not specifically in the care of doctors. There are reasons, good reasons, for not trying

to remove this Bill and then, and trying to include the same, and there must be great care given to what items might be included under it. I think that our recommendations are within the terms of reference of the Bill as its presently

terms of reference of the Bill state that, or define medical services, including as a part of the service, the cost of a portion of medical or surgical care or service or the cost of a portion thereof, and the kind of supervision of the close supervision of a physician.

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To go back a bit, we've been operating special



1 and the university, and we have patients, particularly with
2 rheumatoid arthritis, who are referred to us from all over
3 the province.

4 We solve these treatment problems largely by
5 relatively simple measures, by simple medication, not so much
6 the steroid therapy by the rest environment and protection of
7 the rheumatic disease unit, but also by the physical therapy
8 program, which to us is one of the most important zones of our
9 treatment, and we've learned that it has to be given under very
10 close supervision.

11 For example, the initial efforts of the Society
12 were to establish a home physiotherapy program. This was one
13 of the major efforts in the treatment field, begun about 14
14 years ago, and this has been done across the country, and to
15 be brief, and not give all the figures, we found that the
16 home physiotherapy program was about half as effective as
17 therapy to the same kind of patients in a centre, and the
18 therapists who had to give the home therapy program felt that
19 they needed some guidance and supervision, and the problems
20 better defined for them, and they could not get the medical
21 supervision from the attending physician, even though these
22 were physicians interested enough to ask for this therapy in
23 the first place.

24 Either they had to be in hospital, or they had
25 to have more help than could be given by the general physicians.



and the university, and we have patients, particularly with rheumatoid arthritis, who are referred to us from all over the province.

We solve these treatment problems largely by relatively simple measures, by simple medication, not so much the steroid therapy by the rest environment and protection of the rheumatic disease unit, but also by the physical therapy program, which to us is one of the most important ones of our treatment, and we've learned that it has to be given under very close supervision.

For example, the initial efforts of the Society were to establish a home physiotherapy program. This was one of the major efforts in the treatment field, begun about 14 years ago, and this has been done across the country, and to be brief, and not give all the figures, we found that the home physiotherapy program was about half as effective as therapy to the same kind of patients in a centre, and the therapists who had to give the home therapy program felt that they needed some guidance and supervision, and the program better defined for them, and they could not get the medical supervision from the attending physician, even though these were physicians interested enough to ask for this therapy in the first place.

Either they had to be in hospital, or they had to have more help than could be given by the general physician.



So, the first point is that physiotherapy is a very important part of the treatment of the arthritic rheumatoid patient, and this must continue after they leave hospital.

At the present time we have the problem that as soon as they are discharged from the hospital they must assume the cost of physiotherapy themselves, and it is greater than the cost of their medical supervision, and greater than the cost of medication for a year, and most of them can't assume such costs, and they either -- sometimes they are kept in hospital longer than they need to be, or else they can't have the treatment.

To a certain extent the Arthritis Society can fill, and has filled, this gap, but the gap remains a very large one.

So that we think that this physiotherapy and occupational therapy must be provided as an insured benefit.

Now, the next point is, could it be provided under the hospital services Bill, or other Bills, actually, than the health sphere? Certainly it would not be too difficult administratively to provide care in hospitals, but a growing amount of the well-supervised physiotherapy is given outside of hospital physiotherapy departments, and the opinion is that an increasing amount of therapy should be given under medical supervision at outside therapy centres.

So that it seems clear that the hospital





1 services Bill is not the applicable one for this particular
2 problem.

3 The need for close medical control, or close
4 medical supervision and advice, makes the administrative
5 problem a little bit easier, because this means that a good
6 deal of therapies, or treatments, which aren't specifically
7 medically required, or indicated, and aren't given for a
8 specific medical purpose, would not be covered under these
9 provisions.

10 The exact question of cost is a very difficult
11 one to come into. We've made some effort, but we appreciate
12 that you probably would want some effort, some information,
13 about the size of this problem. We can tell you that about
14 40,000 occupational or physiotherapy treatments a year are
15 given at the Toronto Western out-patient; 20,000 at the Toronto
16 East General; 17,000 at the Toronto General Hospital, and,
17 therefore, we guess from this that about 100,000 such treat-
18 ments would be given in Toronto in the course of a year at
19 the various hospital out-patient departments, or a few
20 privately-run operations.

21 THE CHAIRMAN: Is the cost about five dollars
22 apiece?

23 DR. SMYTHE: I can say in the general hospital
24 about three dollars apiece. Home therapy costs at least five
25 dollars a treatment. I think perhaps the nursing services are



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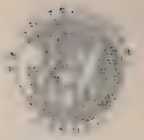
1 also subsidized. We've had a good deal of experience with the
2 home therapy, because that was the initial direction of our
3 efforts.

4 I think that the great majority of people who
5 have a treatment program are better to come under closer
6 supervision to provide home therapy. It still has a place,
7 particularly with someone who has been in hospital, where the
8 treatment program is well laid down, and temporarily the home
9 therapy program may bridge the gap after they leave hospital,
10 or a brief visit in a home with a simpler problem, a few visits
11 by a therapist may solve the problem.

2 12 This brings us to the third recommendation, that
13 the question of social service workers in the community and
14 the home therapy, and other related programs to our knowledge,
15 are a clear statement of the value of these programs to the
16 kind of patients they apply to.

17 The way they control the finances, I don't
18 think that all these problems have been solved, and that
19 further information is needed.

20 We've had ten years' experience, and still
21 can't make a clear recommendation to answer your questions on
22 cost and recommendations, but we rather firmly go into the
23 business of pilot projects, to try to answer this question,
24 and those pilot projects could be given to voluntary agencies,
25 or it could be done through health departments, too.



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I think that the great majority of people who have a treatment program are better to come under closer supervision to provide home therapy. It still has a place, particularly with persons who are unable to come to the treatment program is well laid down, and temporarily the home therapy program may bridge the gap until they can be brought to a hospital clinic in a more permanent manner. A few cases by a therapist may solve the problem.

This brings us to the third recommendation, the question of social service workers in the community and the home therapy, and other related programs in our hospitals are a clear statement of the value of these programs to the kind of patients they apply to.

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We've had ten years' experience, and still can't make a clear recommendation to answer your questions on cost and recommendations, but we rather firmly go into the business of pilot projects, to try to answer this question, and these pilot projects should be given to various departments, or it could be done through health departments, too.



1 I think it's worth getting several different
2 approaches, until we find out more or less an answer.

3 To come back to our recommendations, on page 2,
4 we recommend first:

5 "That insurance be made available to Ontario
6 residents against the cost of necessary
7 physiotherapy and occupational therapy for
8 patients not in hospital, provided that the
9 therapy is prescribed by a physician and super-
10 vised by a physician, and provided that diag-
11 nosis and indication for treatment be subject
12 to periodic independent review.

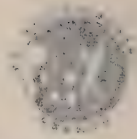
13 "That this insurance be provided under the
14 Medical Services Insurance Act.

15 "The the Government of Ontario sponsor pilot
16 studies through voluntary agencies to explore
17 the technique and value of various health
18 services, not covered by specific legislation."

19 THE CHAIRMAN: Thank you. To what extent is
20 special equipment required for this sort of physiotherapy?
21 Do you use generally any mass treatment? I'm thinking -- I'll
22 tell you why I ask the question.

23 I'm wondering about home treatment. Is this
24 equipment that can be transported easily?

25 DR. SMYTHE: Yes. The reason why the cost of



approaches, until we find out more or less an answer.

To come back to our recommendations, on page 2,

we recommend first:

"That insurance be made available to Ontario

residents against the cost of necessary

physiotherapy and occupational therapy for

patients not in hospital, provided that the

therapy is prescribed by a physician and super-

vised by a physician, and provided that diag-

nosis and indication for treatment be subject

to periodic independent review.

"That this insurance be made available to

Medical Services Insurance Act.

"That the Government of Ontario should

studies through voluntary agencies to explore

the techniques and value of various health

services, not covered by specific legislation."

THE CHAIRMAN: Thank you. To what extent is

special equipment required for this sort of physiotherapy?

Do you use generally any mass treatment? I'm thinking -- I'll

tell you why I ask the question.

I'm wondering about home treatment. Is this

equipment that can be transported easily?

DR. SMYTHE: Yes. The reason why the cost of



1 the therapist is five dollars a day for home treatment is that
2 we have to consider not only her cost, but the cost of the
3 vehicle she travels in, and she needs the vehicle, because she
4 has to carry various lamps, weights, and various other devices
5 which make the therapy possible.

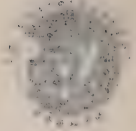
6 MRS. AYLEN: On page 1 you speak of travelling
7 consultant clinics. How do those operate?

8 DR. SWANSON: We felt that there are certain
9 areas of the province where consultant services which are
10 closely related aren't adequate, so we've recommended consul-
11 tant clinics to be held at the request of doctors in the area.

12 The patient doesn't make a direct request.
13 There is one in Cobourg, one in Belleville, and possibly there
14 will be one in Toronto next month.

15 In this consultation, it's a rather unique
16 feature. We have a doctor, an occupational therapist, combined
17 physiotherapy and a social worker. These three go together on
18 the same day, take the person's history, make an examination,
19 assess the patient's social circumstances, and sometimes visit
20 the home and assess the patient's physical functions.

21 The cost of this is borne by the Arthritic
22 Society, who pay the consultant and the therapist. The
23 doctor's salary is guaranteed by the Society up to \$50 a day,
24 provided he doesn't collect it from the patient. If the
25 patient can pay, he should, but if not the doctor collects it



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1 from the Society, and this works very well.

2 MRS. AYLEN: If physiotherapy were included in
3 Bill 163, do you think there are enough physiotherapists in
4 the province to provide all this?

5 DR. SMYTHE: The answer is no.

6 MRS. AYLEN: How many communities have physio-
7 therapists?

8 DR. PEARSON: I think, according to the last
9 study, which was done in 1961, there are about 300 hospital
10 departments in Ontario that have a physiotherapist, or depart-
11 ment, but they don't always have staff, but there are
12 supposedly facilities for 300 physiotherapy outlets in the
13 Province of Ontario.

14 DR. SWANSON: One of our reasons for saying
15 under (iii) that the Government sponsor pilot studies -- we're
16 trying to show what should be done, and it will be done in a
17 couple of years when people are available. There are other
18 studies, short of having new schools, which we hope will be
19 set up.

20 We experimented with the use of tape recorders.
21 We have a travelling physiotherapist who can lay down a
22 course of treatment, and the patient just has to press the
23 button, but this is very difficult to do, and we're experimen-
24 ting.

25 We believe there are pilot studies of this

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We believe there are pilot studies of this



1 which should contribute and be sponsored and supported by
2 government funds.

3 MRS. AYLEN: That covers the third question I
4 had here in your recommendations, that the Government of
5 Ontario sponsor pilot studies through voluntary agencies, and
6 I said what agencies?

7 Could you elaborate on that a little more?

8 DR. SMYTHE: I think that each agency has in
9 its personnel people with a certain amount of interest that do
10 certain things better than anybody else.

11 For example, the Toronto Rehabilitation Centre
12 has been running a home care section for some years, and I
13 think that their experience in this field, and this is a little
14 broader than just home therapy, I think their experience
15 should be built on, rather than duplicated elsewhere.

16 Our own experience in more broad provision of
17 physio- and occupational therapy throughout the province, and
18 the travelling consultation clinics, should be built on. The
19 March of Dimes people have a different kind, and the Crippled
20 Children people have had experience of different sorts of
21 plans, and I think we should borrow from their experience and
22 skills, rather than start to do it all over again from a
23 government agency.

24 MRS. AYLEN: You would co-ordinate that?

25 DR. SMYTHE: Yes.



which would contribute to the operation and expansion of
Government funds.

MRS. AYLEN: That covers the third question I

had in mind in your presentation. Does the Government
concur in the fact that the Commission is a body
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should be built on, rather than duplicated elsewhere.

Our own experience in more broad provision of

services and community therapy, through the provision of

various rehabilitation services, should be built on.

Some of these people have a different kind of experience

Children people have had experience of different kinds of

cases, and I think we should build on their experience and

skills, rather than start to do it all over again from a

MRS. AYLEN: You would co-ordinate that?

DR. SMYTHE: Yes.



1 DR. HAMILTON: " Could you tell me, is the cost
2 of drugs a major item for a patient with rheumatoid arthritis?

3 DR. SMYTHE: Yes. It runs for one patient to
4 well over six hundred dollars. Of that, about thirty-five
5 dollars was the cost of my services, and over three hundred
6 dollars was the cost of drugs, and the rest were various
7 things like shoes.

8 DR. HAMILTON: Drugs alone would be three
9 hundred?

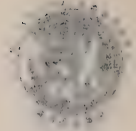
10 DR. SMYTHE: Yes.

11 DR. HAMILTON: What does the patient do that
12 can't afford to buy these?

13 DR. SMYTHE: If we can certify them as being
14 chronically disabled, or being qualified for welfare, or if
15 they fall into the terms of reference of some of these, or
16 under D.V.A. or the Workmen's Compensation Board, such people
17 can be covered by this mechanism.

18 If they attend the arthritis clinics of the
19 teaching hospitals, and aren't covered by any of these Acts,
20 then the hospital provides the drugs at a loss, or for free,
21 or for whatever the patient can afford to pay, and tries to
22 recover their debts from the City, with whatever success they
23 may have.

24 DR. HAMILTON: That's when they are treated as
25 out-patients?



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DR. HAMILTON: That's when they are treated as

out-patients?



1 DR. SMYTHE: That's right.

2 DR. HAMILTON: Would the cost of physiotherapy
3 drugs and appliances be as great as the medical costs, the
4 professional fees, for looking after the patient?

5 DR. SMYTHE: I think in nearly all cases they
6 would be much larger, because if they come to see us at a
7 reasonable interval it's not going to cost them much more than
8 ten, fifteen, dollars a month, whereas if they have therapy
9 visits at fifteen dollars a week, and they might have fifteen
10 dollars a month, or more, in drugs.

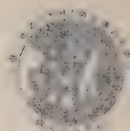
3 11 DR. HAMILTON: So that the cost of drugs,
12 physiotherapy treatments, and special appliances which they
13 may need, would be greater than the cost of professional
14 services rendered?

15 DR. SMYTHE: Yes.

16 MR. MAJOR: Doctor, I think you've answered my
17 question, but just to be sure, did you say that in relation to
18 page 5 the independent medical review would cost about ten or
19 fifteen dollars a month?

20 DR. SMYTHE: No. The question here is what do
21 you do with the physiotherapist who gets a prescription and
22 uses it, and keeps on doing it when the treatment is not bene-
23 fitting the patient any more?

24 The Compensation Board have run into this
25 problem, and after ten or twelve treatments they have the



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1 power to call for an independent review. I think this is a
2 mechanism that would not have to be called into action very
3 often, but we hear horror stories about one physiotherapist in
4 Saskatchewan earning \$80,000 a year, and there has to be
5 mechanism to prevent that.

6 MR. MAJOR: This review - is it more or less an
7 ordinary home call charge, or is it up in the professional
8 scale of consultation?

9 DR. SMYTHE: It would be consultation.

10 MR. MAJOR: They would review the whole case,
11 probably change the drugs and physiotherapy, and so on?

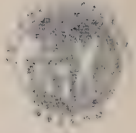
12 DR. SMYTHE: Yes, but this would be undesirable.
13 I think it should be the original team and the patient's own
14 physician, and he call in a consultant if necessary, without
15 the agency stepping in.

16 MR. MAJOR: This would happen how often? Once
17 every three months, or how often?

18 DR. SMYTHE: No, I think this would happen
19 about once every fifty or a hundred patients.

20 MR. MAJOR: No, the period?

21 DR. SMYTHE: I think we're talking about two
22 different things here. A patient who develops rheumatoid
23 arthritis where any kind of a treatment problem exists is
24 often referred by the family physician to a rheumatologist
25 for advice about how the treatment should be carried out, and



power to call for an independent review. I think this is a
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a last resort, something that would be used only in the
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1 this could happen ten or fifteen times in the course of ten
2 years' treatment, and in between consultations the family
3 physician would run the day-to-day care.

4 What's described in here is a different
5 mechanism entirely. It's a way the people administering the
6 Bill would have of protecting themselves from an unfortunate
7 arrangement should the physiotherapy be prescribed unwisely
8 and in excessive amounts.

9 MR. MAJOR: You talk about the number of physio-
10 therapists attached to hospitals. Would this physiotherapist
11 treatment, could it be handled through physiotherapists in
12 private practice under the direction of a physician?

13 DR. SMYTHE: Yes. I think at present it's being
14 done largely through hospitals because, not only are physio-
15 therapists short, but medical people trained in the skills are
16 also perhaps even more critically short. So, to make maximum
17 advantage of their time, the patients and the physiatrists and
18 the physiotherapists are concentrated. This means that some
19 people have to do without, because they don't live close to
20 the centre, or would have to travel, and lose part of the
21 advantage by the long distance to travel home.

22 I think there are about twelve physiatrists
23 who run private clinics divorced from hospitals.

24 MR. MAJOR: So you can see a growing force of
25 physiotherapists in private practice, who could get into this

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1 work?

2 DR. SMYTHE: Yes.

3 MR. MAJOR: Is there any particular relationship
4 between people who are doing occupational therapy and physio-
5 therapy? Is there more physio- than occupational? You said
6 that the occupational therapists had a great need?

7 DR. SMYTHE: There are something like two-and-a-
8 half times as many physio- as occupational therapists. Many
9 of the centres give them joint training; the problems and the
10 ways they approach them are very close, so that the girls are
11 usually trained in both, and the two skills may be dealing with
12 the problem of a hand. At one point it may be better to
13 concentrate on the exercise program as an exercise, and another
14 time it might be better to get them weaving, or doing a physi-
15 cal activity. They are very close.

16 MR. MAJOR: Are the drugs involved in this drugs
17 that can only be obtained through a prescription?

18 DR. SMYTHE: Yes. A great amount of the most
19 useful drugs we have are salicylates, Aspirin, Bufferin, and
20 so on, but the dosages we want to give them, I think, usually
21 are bought under prescription under our specific advice as to
22 side effects.

23 MR. MAJOR: This would be an exceptional case
24 for the individual? Most of the individuals could buy these
25 drugs, the salicylates, without having to pay a professional



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the provision of a fund. At one point it may be better to

concentrate on the business program as an occupational and physio-

therapy is right at home in the business world, as being a physio-

cal activity. They are very close.

MR. MAJOR: Are the drugs involved in this drugs

that can only be obtained through a prescription?

DR. SMYTHE: Yes. A great amount of the most

valuable drugs are barbiturates, sedatives, hypnotics, and

anesthetics, and these are used in the treatment of many

and physical mental conditions, and are especially useful in the

side effects.

MR. MAJOR: This would be an exceptional case

for the individual? Most of the individuals could buy these

drugs, the sedatives, without having to pay a professional



1 pharmacist's fee?

2 DR. SMYTHE: Yes.

3 MR. MAJOR: But in specific cases where the
4 dosage is quite high and should be maintained by the physician
5 only, these you would handle under prescription?

6 DR. SMYTHE: Well, most of the cases that
7 require medical care, they require specific control of dosage.
8 It's also to their advantage, of course, because many of them
9 are eligible for income tax deduction.

10 MR. MAJOR: I'm glad you brought it up, Doctor,
11 because this was one of the problems I was coming to.

12 Are these prescriptions issued purely and
13 simply to get a benefit through income tax?

14 DR. SMYTHE: No, I would say not. For example,
15 a rheumatoid patient, one of the things we have to persuade
16 most of them to do is to take a dose of Aspirin, say, which
17 might be equivalent to ten or fifteen tablets a day.

18 There's a definite medical reason for this,
19 not just as a pain reliever. We may have to change, and give
20 them a different form, which is only given on prescription,
21 and some of these side effects can sneak up on them without
22 them being aware that they should only be given under medical
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/PE/rps 1 MR. CASWELL: Doctor, you have a large number
2 of rheumatics and arthritics throughout the province, not
3 just in the larger centres?

4 DR. SMYTHE: Yes, there would be about a
5 quarter of a million with rheumatoid arthritis.

6 MR. CASWELL: How many rheumatologists do you
7 have in the province?

8 DR. SMYTHE: About ten.

9 MR. CASWELL: And they are located in the
10 larger centres, I assume?

11 DR. SMYTHE: Yes.

12 MR. CASWELL: What I am concerned about is that
13 you are suggesting physiotherapists and occupational therapists
14 be brought within the scope of the Bill and I well recognize
15 the need for this treatment, but you are suggesting that it
16 be under the supervision and direction of a physician?

17 DR. SMYTHE: Yes.

18 MR. CASWELL: My experience is that the majority
19 of the physicians are quite convinced that there is no cure
20 for arthritis, in the first place, and, therefore, the best
21 thing to do for the patient is to prescribe a drug which will
22 ease or help to relieve the pain because they know very little,
23 apparently, about any treatment for arthritis. And if this
24 physiotherapist is going to be recommended by a physician
25 and they are going to be working under the supervision and



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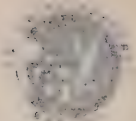
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MR. CASWELL: What I am concerned about is what
you are doing to help the patients who are suffering from
be brought within the scope of the Bill and I will recognize
the fact that this is a very serious condition and it
be under the supervision and direction of a physician?
DR. SMYTHE: Yes.
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of the physicians are quite convinced that there is no cure
for arthritis, in the first place, and, therefore, the best
way to help the patient is to relieve the pain and to
ease or help to relieve the pain because they know very little
apparently about any treatment for arthritis. And it seems
that the physician is going to be responsible for a physician
and that the role is to relieve the pain and to



1 direction of this physician, it would seem to me that you are
2 still only going to have the benefit in the areas where you
3 have a rheumatologist who specializes in this?

4 DR. SMYTHE: We are keenly aware of that point
5 and we have made recommendations in our own program and through
6 the Dominion Health Services survey, Royal Commission, that
7 establishment of rheumatic disease units be placed geographically
8 so that all areas will have special consultation facilities
9 made available to it and that from each of these units we will
10 run travelling consulting service. It is obvious that this is
11 going to take time to develop. We are going to need at least
12 75 new rheumatologists in the next 10 years. The alternative
13 is to write the Bill in such a way that unsupervised therapy
14 is covered and we think that this is the kind of thing that
15 may often prevent people seeking the help that they require
16 and need and that we should not be in the position of subsidizing
17 and perpetuating bad medical care. We should be in the
18 position of doing all we can to make good medical care available.

19 MR. CASWELL: I agree that it would be just
20 as harmful done wrong as right, but what I am concerned with
21 is that there are arthritics all through the country in these
22 small areas and I think the idea of setting up your clinic is
23 good. But in setting up your clinic, these people are not going
24 to be able to travel, a good many of them, 40 miles two or
25 three times a week for a physiotherapist to give them treatment



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small areas and I think the idea of setting up your clinics as

to be able to travel, a good many of them, 40 miles two or



1 and, in my mind, I can see the good points in what you are
2 proposing. But I am trying to ascertain how you get this
3 service to a vast number of people in the small areas through-
4 out the country and who are not going to be in an area close
5 enough to a physiotherapist?

6 DR. SMYTHE: There is no way that we can set
7 up a government way of avoiding this except to have family
8 physicians which know all about what we are talking about and
9 what facilities are available, and this is another major part
10 of our treatment program, to try to get the message, the story
11 about advances in physiotherapy, and it is extraordinary that
12 we think that physiotherapy, being a matter of just exercise,
13 must be stationary. Our understanding is advancing almost
14 as fast as our knowledge of drug techniques. So we have a
15 major duty of trying to get this advance in treatment out to
16 the family physicians. That there is no cure for arthritis
17 is the dictum of the medical schools of 20 years ago, and it
18 is true; but it is interpreted by the patient as there is no
19 treatment for rheumatoid arthritis and that is not true.

20 MR. CASWELL: I am very convinced of the good
21 treatment. I find that the family physician is more and more
22 attending special clinics and I have been wondering if your
23 group who have taken on this responsibility have held such
24 clinics, invited the doctor and helped him get better acquainted

25 DR. SMYTHE: Yes, we have. All of us go out on



1 travelling clinics, sponsored by the university. We run post-
2 graduate courses and try to reach the doctors directly, as well
3 as through medical journals and other things. I think that
4 the direct contact is much more important.

5 MR. CASWELL: I think that is all, thank you.

6 THE CHAIRMAN: Any further questions?

7 DR. GALLOWAY: I take it that you are not
8 concerned only with the physiotherapy treatments for arthritis
9 and arthritic patients, but you are recommending that the
10 services of physiotherapists in general be an insured service?

11 DR. SMYTHE: Yes. Where it is prescribed for
12 medical reasons and by a physician and under their supervision.
13 I think it wouldn't be fair or right to restrict it only to
14 arthritics.

15 DR. GALLOWAY: You spoke of 250 or 300 thousand
16 patients with arthritis in the province at the moment?

17 DR. SMYTHE: Rheumatoid arthritis. There are
18 others with other types.

19 DR. GALLOWAY: What would be the number of
20 arthritic patients?

21 DR. SMYTHE: The estimate of the number who are
22 troubled with arthritis would run as high as about 20 per cent
23 of the population. This would include back pains, neck pains,
24 shoulder pains, and so on, under the category of arthritis,
25 which it is.



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MR. GAWWILL: I think that is all, thank you.

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1 DR. GALLOWAY: Do you prescribe physiotherapy
2 to the same extent for this type of arthritis as you do for the
3 rheumatoids?

4 DR. SMYTHE: Under certain circumstances. For
5 example, somebody with an acute problem of a cervical spine,
6 physiotherapy may be very important. Under others, it may be
7 less important.

8 DR. GALLOWAY: Have you any idea of the three
9 hundred thousand rheumatoids, what percentage of them would be
10 receiving treatment at any one particular time and, if so, what
11 would be the average length of treatment?

12 DR. SMYTHE: There are several surveys that
13 give figures on this, but roughly about a tenth of them will
14 be under active treatment at any one time and the average length
15 of treatment for these things is something like 85 days.

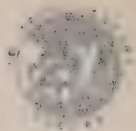
16 DR. GALLOWAY: The treatment you are speaking of
17 is physiotherapy treatment?

18 DR. SMYTHE: This would be accommodation and
19 close medical supervision, plus pills, plus physiotherapy.

20 DR. GALLOWAY: If this home therapy was instituted
21 to a greater extent than it is, what would be the average number
22 of patients that a physiotherapist could treat at home?

23 DR. SMYTHE: We have figures on that.

24 DR. PEARSON: It runs now, over the 15 years that
25 we have been in operation -- the average number of patients that



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1 a girl could treat in a day would be approximately five -- four
2 and a half one day and five and a half the next, if you averaged
3 it over the week.

4 DR. GALLOWAY: Of your arthritic type of
5 treatments that are done as out-patients in a hospital, how
6 many would a girl be able to handle?

7 DR. PEARSON: Fifteen to twenty.

8 DR. SMYTHE: This is one reason for -- and
9 Dr. Pequegnat suggested you have a choice of either cases being
10 treated in the hospital or being treated at home. We would
11 like to have a lot of them coming into a centre as out-patients
12 for the treatment.

13 DR. SWANSON: They are not visualizing everybody
14 is going to be treated at home, because this is not necessary.
15 Transportation can get them to out-patient clinics. The
16 motivation of getting them on their feet is good. A lot of
17 people don't get out, for these three reasons, motivation,
18 transportation and convenience. If the transportation is
19 available and the doctor gets them motivated, most of these
20 people would come to a clinic and if we get them out of
21 hospital in two weeks, it would be cheaper and we visualize
22 that there be many out-patient centres, some privately-run but
23 most hospital-run, which would take away from the number of
24 days they would have to spend in the hospital and the number
25 of days that they would have to be treated at home.



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It is a matter of motivation. If the patient is

available and the doctor gets them motivated, most of these

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most hospitals, which would take away from the number of

patients who would have to be in the hospital and the number

of days that they would have to be treated at home.



1 MR. CASWELL: If the treatment were provided,
2 the motivation and the transportation would pretty well take
3 care of themselves?

4 DR. SWANSON: I think so.

5 DR. PEARSON: One-third of the patients we
6 treat in the City of Toronto, around a thousand a year, don't
7 pay anything towards their treatment. One-third can pay full
8 fees and one-third can pay part. It pretty well drops every year
9 into those three categories. Now, part may be anything from
10 50¢ to \$3.50.

11 DR. GALLOWAY: I understand that you as an
12 organization have your own physiotherapists?

13 DR. SWANSON: Yes.

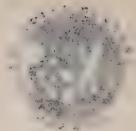
14 DR. GALLOWAY: Do you pay them on a salary or
15 on a fee-for-service?

16 DR. PEARSON: No. They are employed--they are
17 on a salary.

18 DR. GALLOWAY: This would be true of the ones
19 in the out-patient department, too?

20 DR. PEARSON: Yes.

21 DR. SWANSON: In the Hamilton area the Society
22 has just sponsored the opening of the rheumatic disease unit.
23 Now, this is the place for treatment for the arthritics in
24 the whole of the Hamilton district, which goes out to South
25 Wellington and based on that will be probably a consultation



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22 has been organized and it has been organized in
23 the same way as the Society in the Hamilton area. It
24 has been organized in the same way as the Society in the
25 Hamilton area and it will be probably a combination



1 clinic. Patients will be brought as out-patients or they may
2 have their out-patient treatment in other districts. This will
3 take place in at least eight other areas in the province.

4 DR. GALLOWAY: If the services of the physio-
5 therapist were insured under this Act, would you think that
6 they should be treated differently than you are treating them
7 now? Would it be on a fee-for-service basis?

8 DR. SMYTHE: I left this vague. One thing we
9 visualize, for example, is that it might be necessary to include
10 it in this Act that the total responsibility for providing
11 the service would have to be assumed by the supervising
12 physician. In other words, that he would bill for physio-
13 therapists service in the same way that a radiologist bills
14 for the radiological technician's service. I do not know if
15 I would like this to happen or not, so I left this part of it
16 as a detail that might be dealt with in other ways.

17 DR. GALLOWAY: I am only smiling because the
18 physiotherapists may have something to say about it, too.

19 DR. SMYTHE: I think they are very anxious to
20 work under good medical supervision and I think this part of
21 our recommendation they agree with. On the question of how
22 they should be paid, I do not think we have very strong views
23 on it.

24 DR. GALLOWAY: Thank you very much.

25 DR. BUTT: What is the source of your funds at the



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24. DR. GALLOWAY: Thank you very much.
25. DR. BUTT: What is the source of your funds at the



1 moment?

2 DR. SMYTHE: It is all private and donated.
3 In Toronto, the largest source is through the United Appeal.
4 We have campaigns to get monies from United Appeals in other
5 communities and also in other types of campaigns. None of
6 it comes from the government.

7 DR. PEARSON: Yes. Some of it does -- from the
8 Federal level, until this past year, and some from the
9 provincial. But the Federal level is through the provision
10 of equipment which we use and this was cut off about a year
11 ago and the province has made a straight, modest grant to the
12 Society.

13 DR. BUTT: That is the Canadian Arthritis and
14 Rheumatism Society?

15 DR. PEARSON: Yes.

16 DR. BUTT: What is your relationship with the
17 United States?

18 DR. SMYTHE: None at all.

19 DR. BUTT: You are not related at all?

20 DR. SMYTHE: No.

21 DR. BUTT: Do you also have research fellow-
22 ships, and so on?

23 DR. SMYTHE: Probably the most important part
24 of our program would be the development research program.

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1 large funds for this?

2 MR. SMYTHE: Yes.

3 DR. BUTT: The other thing is what about the
4 actual surgical part? Does this ever come into your field?
5 I notice you haven't even mentioned it?

6 DR. SMYTHE: Through the rheumatic disease unit,
7 the patients are brought to the hospitals and there the surgical
8 treatment is done and much of the physiotherapy that we have
9 to supervise is post-operative physiotherapy.

10 DR. BUTT: So there are quite large areas:

11 (1) in research

12 (2) in surgery and physician's care that will
13 be utilized one way or another, if it is available?

14 DR. PEARSON: That is right. That is why we
15 concentrated on that one section.

16 DR. BUTT: But there is quite a bit of it
17 in the treatment of rheumatoid and other types of arthritis?

18 DR. PEARSON: Yes.

19 DR. BUTT: It is taken care of?

20 DR. PEARSON: Yes. The great bulk of it is.

21 THE CHAIRMAN: Any further statement that you
22 wish to make? I presume there are no further questions.

23 DR. PEARSON: Thank you very much for your
24 very interesting questions.

25 THE CHAIRMAN: Thank you, gentlemen.

---Whereupon the hearing adjourned until 10:00 a.m., Tuesday,
the 28th day of January, 1964



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